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Ontario Council
of Health on

Annex "B"

Physical Resources

Ontario Department of Health
Honourable Thomas L. Wells, Minister

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PHYSICAL RESOURCES

ONTARIO

REPORT OF THE ONTARIO COUNCIL OF HEALTH

on

PHYSICAL RESOURCES

ANNEX "B"

JUNE 1969

ONTARIO DEPARTMENT OF HEALTH
Honourable Thomas L. Wells, Minister

Produced for the
ONTARIO COUNCIL OF HEALTH
by the
COMMUNICATIONS BRANCH
ONTARIO DEPARTMENT OF HEALTH

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FOREWORD

This report, which was prepared by the Committee on Physical Resources, was presented to the Ontario Council of Health in June 1969. It was reviewed by the Council, and approved after a few minor amendments were made with the agreement of the Committee chairman and members attending the Council meeting.

Readers are reminded that while the Ontario Council of Health has endorsed the report as printed here, it did so without formally attempting to co-ordinate the views and recommendations presented with those presented by other Committees of Council. In view of this, it is possible that Council could adopt a modified position when the influences of recommendations by other Committees are assessed.

This report emphasizes the need to develop a balanced and dynamic health care delivery system which will incorporate the features of efficiency, economy, and effectiveness, and will include a method for on-going evaluation. Only in this context, it is stressed, can physical resources be considered meaningfully. Many problems are outlined which have resulted from the lack of an overall system and from the lack of co-ordination among the organizations involved in planning and operating all types of personal health care services at the provincial and local levels. Recommendations for action are set forth which, the Council believes, will alleviate present shortcomings and pave the way for the development of a future system.

The future activities of this Committee are now under review to determine problem areas which warrant further investigation.

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Mr. D. Buck, Architect	Messrs. Page & Steele, Architects, Toronto
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ACKNOWLEDGEMENTS

Technical support in the preparation of this report was provided through the auspices of the Research and Planning Branch of the Ontario Department of Health. Under Dr. G. W. Reid, Director, the following staff members worked with the Committee:

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Acknowledgement is also given for the assistance provided by staff members of the Departments of Health and Social and Family Services, and the Ontario Hospital Services Commission.

Recommendations

RECOMMENDATIONS

The recommendations of this report are listed below to provide a quick guide for the reader. The Ontario Council of Health has approved the recommendations as presented or has taken action as indicated.

Report of the Committee

SECTION I

Introduction

Terms of Reference

1. The Committee on Physical Resources was given the following terms of reference by the Council:

   This Committee would be concerned with the short- and long-term trends in the supply and demand for physical resources with a projection of future requirements. Two major areas have been identified, namely physical facilities needed for education, training, and research, and those required for service programmes.

2. In the initial discussions the Committee recommended the words "supply and demand" used in the terms of reference should be changed to "availability and need."

Organization of the Report

3. The report consists of three parts. First, the Introduction which describes the Committee's task and the method of investigation and reporting. Second, the Conclusions and Recommendations, which list the main findings and recommendations of the Committee under appropriate headings. Finally, as Appendix A, a supporting Background Paper which contains, in outline, the evidence and considerations which led the Committee to the conclusions and recommendations which are submitted.

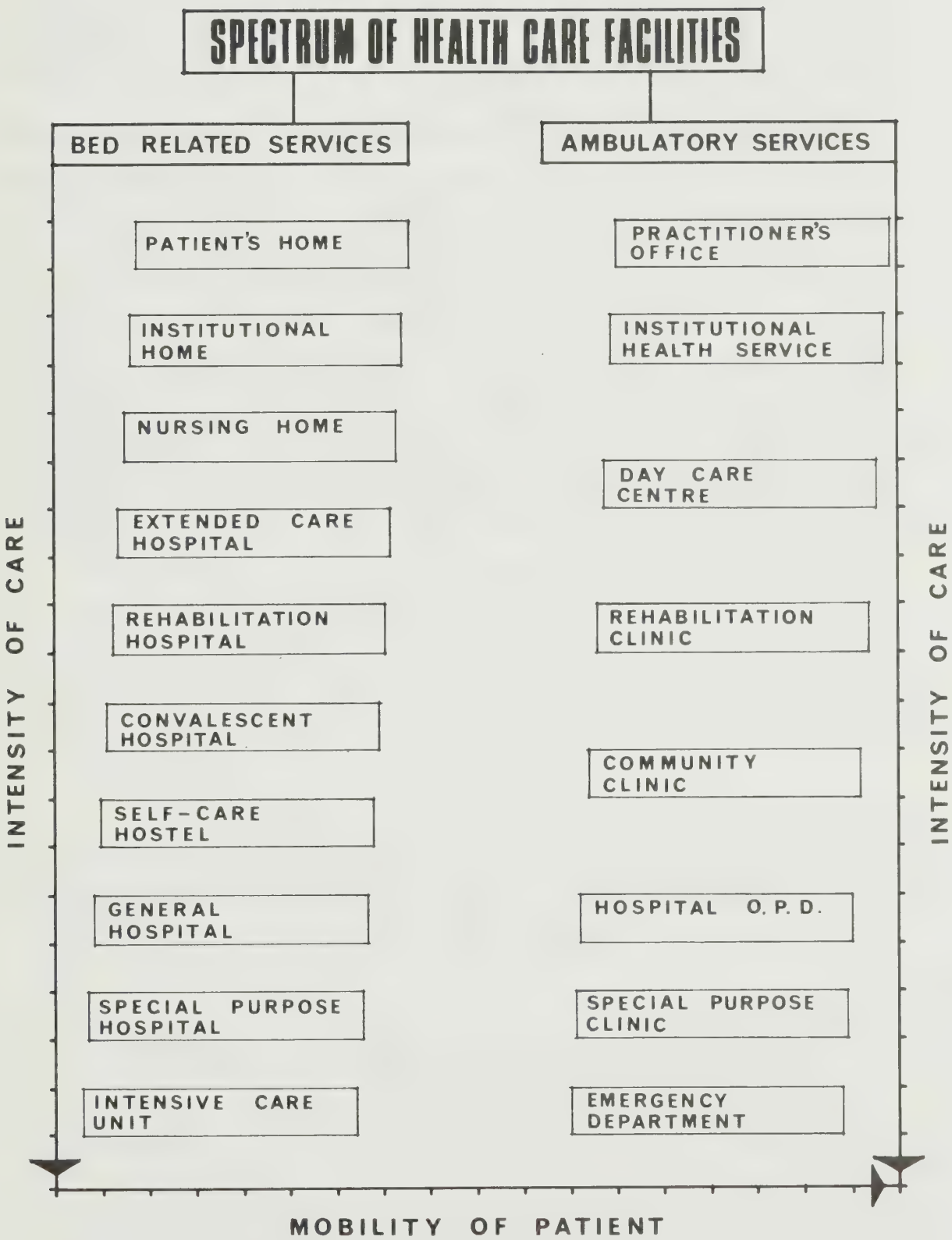
Methodology of Committee Investigations

4. Discussions on the definition of the Committee's task were held during the early meetings. It became evident at the outset that, to determine precisely the role of future health care facilities, a definition of the health care delivery system was necessary, since physical resources must be responsive to changing needs and concepts of health care. Responsibility for such a definition was beyond the terms of reference of the Committee on Physical Resources; nevertheless, a broad basis of understanding of a health care delivery system was essential to the Committee in proceeding with its task. Consequently, discussions were undertaken of such matters as the need for the system to take into consideration the continuity of care to patients, convenience, and accessibility of care at all times, and personalization of the delivery of health care. In addition, the Committee found it necessary to devote considerable time to the consideration of a functional spectrum of health facilities in relation to the system of delivery of health services. A schematic representation is shown in Figure 1. The establishment of a functional spectrum was not intended to be an end in itself, but rather to serve as a guide or frame of reference to assist the Committee to maintain a broad perspective and comprehensive approach to all facilities required for the provision of a complete range of health services.

5. Concurrent with the above described activities, the Committee carried out investigations of the current position and policies of the agencies concerned with health care in Ontario, placing particular emphasis on the role, use and requirements of physical resources. The policies and forecasts of other jurisdictions were considered also, and comparisons were made. These activities allowed the Committee to obtain an overview of the current situation in Ontario and to reach conclusions with respect to the present methods of planning, designing, and establishing, and of operating physical resources.

6. With this background, the Committee then turned its attention to the development of recommendations for action which would alleviate present shortcomings and also pave the way for the development of a future system. The Committee constantly kept in mind that a future system should incorporate the features of viability, flexibility, efficiency, and economy, and at the same time provide physical resources that would contribute to the realization of the highest standard of health care for the people of Ontario.

FIGURE 1


SPECTRUM OF HEALTH CARE FACILITIES
BED RELATED SERVICES
AMBULATORY SERVICES
PATIENT'S HOME
INSTITUTIONAL HOME
NURSING HOME
EXTENDED CARE HOSPITAL
REHABILITATION HOSPITAL
CONVALESCENT HOSPITAL
SELF-CARE HOSTEL
GENERAL HOSPITAL
SPECIAL PURPOSE HOSPITAL
INTENSIVE CARE UNIT
PRACTITIONER'S OFFICE
INSTITUTIONAL HEALTH SERVICE
DAY CARE CENTRE
REHABILITATION CLINIC
COMMUNITY CLINIC
HOSPITAL O. P. D.
SPECIAL PURPOSE CLINIC
EMERGENCY DEPARTMENT
INTENSITY OF CARE
INTENSITY OF CARE
MOBILITY OF PATIENT

Limitations of Committee Investigations

7. The Committee found that there was insufficient time to complete a thoroughgoing review and report on the physical resources related to education, training, and research, and the facilities of an auxiliary nature which form part of the total system. Also, time did not permit a full review of the facilities related to programmes for children with emotional disorders and for mentally retarded persons.

8. The attention of Council is drawn to the fact that the briefings and discussions on the present situation and policies in Ontario were held almost entirely with Division and Branch level representatives of the official agencies of the Departments of Health and Social and Family Services and the Ontario Hospital Services Commission. The Committee intended that the views of persons at the operating level be obtained and substantiated by onsite visits, but the time required precluded this approach. Moreover, it was impracticable to consult voluntary and professional organizations or representatives of the consumers of health care. The views of the Committee, consequently, may be biased since the preponderant sources of information were those responsible for present policies and procedures.

SECTION II

Conclusions and Recommendations

9. This part of the report deals first with the conclusions and recommendations that apply to all components of the overall pattern of health services, both physical and mental. These are followed by those that apply more specifically to the individual components.

10. Because physical resources must be planned and operated to support the programmes on which the future health care delivery system should be based, conclusions and recommendations are made on programmes where they directly influence the physical resources system.

11. A number of recommendations have been selected for special emphasis because of their importance in terms of policy or because they should be implemented immediately. These recommendations have been starred.*

OVERALL PATTERN OF HEALTH SERVICES

Conclusions

12. The present pattern of health services in Ontario cannot be regarded as a co-ordinated system. It is characterized by gaps in some areas, overlaps in others, and unnecessary and wasteful duplication in facilities and programmes. Unwarranted separation

exists between facilities and programmes for the physically ill and the mentally ill, and between preventive, diagnostic, therapeutic, and rehabilitative services. This fragmentation has contributed to rising costs and to inefficient use of manpower and physical resources.

13. Costly hospital care has been overemphasized while less costly alternatives, such as ambulatory services and care provided in the home, have not been developed to their full potential. Evidence exists that the volume of in-patient care provided by hospitals is unnecessarily high. At the same time, indications are that patients do not always receive care in the type of facility appropriate to their actual needs.

14. There is a lack of co-ordination among the organizations involved in planning and in operating all types of health services. This exists centrally, within the Department of Health and its agencies, and between these and other Departments of Government. Co-ordination at the local level is also lacking. An inter-related problem is the complicated nature of the present regulations, methods, and procedures for the financing of different health services.

15. No integrated methods now exist for the financing of an individual's care through the range of facilities and programmes now available. This leads to inappropriate use of these services and impedes the free flow of patients among health care and related facilities.

16. Sufficient information is not available to form the comprehensive base required for the co-ordinated planning, organization, and employment of resources to support a future health services system or for use in evaluation.

17. Too little research is now being undertaken in such areas as the operation of various components of health services, new forms for the delivery of health care, and methods of remuneration for professional health personnel, all of which may profoundly influence the quality and type of health facilities.

18. There is insufficient local involvement in the planning and co-ordination processes for physical resources related to the overall health services system. In this regard, the Committee endorses the principles set forth in the Report of the Committee

on Regional Organization of Health Services as submitted to the Ontario Council of Health in January 1969.

Recommendations – Overall Pattern of Health Services

* *RECOMMENDATION 1*
THAT, in order to facilitate co-operation and co-ordination in the planning of facilities and the establishment of policies governing the operation of programmes, the Government of Ontario establish a mechanism for co-ordinating the efforts along these lines of all the individual agencies involved in preventive and therapeutic services, physical and mental health services, public health and hospital services, with a view to avoiding duplications, gaps, conflicts and inconsistencies. Such a co-ordinating group should be organized to be responsive to the varying needs of the consumers and providers of health care.

* *RECOMMENDATION 2*
THAT services and facilities for the mentally ill and for the retarded be planned, operated and financed within the context of general health services, and that the role of the Department of Health be redefined now with a view to:

a. integrating psychiatric treatment services with all other treatment services;

b. integrating those activities designed to promote better mental health and to prevent psychiatric disorders throughout the province with the total effort of this nature in the Department;

c. integrating the financing of capital and operating costs for adequate psychiatric and mental health services to provide comparable standards of care with other health care programmes. The same principles should apply.

RECOMMENDATION 3
THAT the Province establish regional and district health councils and delegate to these councils appropriate responsibility and authority. The

responsibilities of these councils should include review of institutional plans in terms of area-wide objectives and appropriate encouragement of use of different types of facilities by the public, by the health professions and by those responsible for the administration of the health facilities.

RECOMMENDATION 4
THAT the methods and procedures related to the planning, operation, and financing of health services be co-ordinated and simplified.

RECOMMENDATION 5
THAT a functional spectrum of health facilities, as outlined in Figure 1 and Attachment 1 to Appendix A, for the care of patients in and out of hospital serve as a frame of reference to encourage a broad perspective on the part of those responsible for co-ordinating, planning, operating and studying individual facilities in the system for delivering health care.

RECOMMENDATION 6
THAT, within the functional spectrum, the levels and types of health services which should be delivered in each facility be defined and that shared services or co-operative working arrangements among institutions be promoted where they may lead to more effective or economical deployment of health resources.

RECOMMENDATION 7
THAT studies be undertaken to determine ways by which improvements can be made in the operational efficiency of all components of the health care delivery system.

RECOMMENDATION 8
THAT formal liaison mechanisms be established to co-ordinate activities of health and other related agencies involved in the continuum of care, especially for those who cannot live independently. In particular, this would involve the Departments of Health, Social and Family Services, and Education.

* *RECOMMENDATION 9*
THAT studies of institutionalized and non-institutionalized populations be undertaken to determine what current needs are for various levels of care, types of programmes and facilities, and that demonstration projects be initiated on alternative possible ways of meeting these needs to ensure that the new policies introduced will result in the provision of care in the most effective and economical manner.

RECOMMENDATION 10
THAT the studies indicated in Recommendation 9 be co-ordinated with a review of standards on which the planning of health services is based, and a review of the methods by which these standards are applied, with a view to establishing planning ratios more precisely related to levels of care appropriate to patient needs.

RECOMMENDATION 11
THAT the present arrangements for financing the individual's care be studied, with a view to developing methods to ensure the free flow of patients among the components of the system, and to eliminate the inappropriate use of facilities and programmes.

* *RECOMMENDATION 12*
THAT encouragement be given, and direct financial assistance be made available starting in the 1969/70 fiscal year, to public or non-profit organizations to develop experimental or demonstration projects concerned with new approaches to the delivery of health care. Provision should be made for careful evaluation of the operation of such programmes.

RECOMMENDATION 13
THAT the Province support a programme to standardize nomenclature of facilities and programmes related to health services at least in Ontario and preferably throughout Canada.

ACTIVE TREATMENT HOSPITALS
(See also Comments in Appendix A, Part I, 42-57)

Conclusions

19. Active treatment hospitals form the backbone of institutionalized health services. They are seriously affected by the lack of a co-ordinated and integrated system for the delivery of health care, in the context of which the need for various types of physical resources can be considered. They would benefit from a restructuring of functions within a regionalized system, and the delegation of responsibility and authority to permit more local involvement and adaptation within provincial standards and guidelines, and better local co-ordination of operational activities.

20. The present methods and procedures involved in the process of planning for active treatment facilities seem unnecessarily complicated, restrictive, and time consuming, and there seems to be too much preoccupation with detail.

21. While patient care is the overriding consideration in the planning process, top financial priority must be given to considerations relating to functional efficiency and manpower utilization, since total operating costs in a period of three years may be expected to exceed initial capital outlay. In this respect, at the local level, health and administrative personnel who will have continuing responsibility for the operation of the facility after its completion, should be deeply involved at the planning stage.

22. There is evidence, from comparison with other jurisdictions, that the volume of in-patient care provided by active treatment hospitals is unnecessarily high, and that too many beds of this category are in operation in the province. The admission and days of care rates and average duration of stay are all higher than in almost any region of the U.S.A. Furthermore, there are noteworthy differences in utilization rates when studied from the viewpoint of county of residence or diagnostic category. Too much accommodation designed for care of the acutely ill is occupied by those who could be more appropriately cared for in an ambulatory setting or at home, or in bed-related facilities which are less costly to operate and which are specifically designed and staffed to meet particular patient needs.

23. Over half the hospitals are under 100 beds in size, and nearly one-third are under 50 beds. In many instances the small size, which is judged to limit the quality of services rendered, cannot be explained on the basis of sparse population.

24. Too much emphasis is placed on in-patient care by the public, by the physician, and by the hospital administrator. This is accentuated by hospital financing and medical insurance mechanisms. Future insurance schemes should be sufficiently comprehensive and so designed as to provide no incentive for in-patient hospital care.

25. Rising costs of hospital operation are of concern, and the present method of operational reimbursement does not provide incentives for efficient management. It is recognized that the ultimate control of costs is through control of bed numbers. Nevertheless, more information should be made available to suggest methods by which hospitals could reduce the volume of in-patient care provided, and improve operating efficiency.

Recommendations – Active Treatment Hospitals

RECOMMENDATION 14
THAT the entire process of programme and project planning for active treatment facilities be re-evaluated, with respect to incentives for responsible and innovative planning and simplification of techniques for monitoring and approval, and with respect to the roles and responsibilities of institutional, community, district, regional and provincial authorities.

RECOMMENDATION 15
THAT encouragement be given to the involvement in programme and project planning at the local level of the health and administrative personnel who will have continuing responsibility for the operation of the facility after its completion, and that steps be taken to make available to these professional providers of care comparative operational and medical data for use in planning and management.

RECOMMENDATION 16
THAT the studies of a representative sample of

institutionalized and non-institutionalized populations, recommended elsewhere in this report, be undertaken to determine what current needs are for various levels of active treatment care, and that careful analysis on an area-wide or regional basis be made of the alternative possible ways of meeting these needs (e.g., in an ambulatory or bed-related setting). These studies should lead to the development of new planning ratios, and of new methods by which these are applied.

* *RECOMMENDATION 17*
THAT, until needs are more clearly defined (as a result of the studies in Recommendation 16), expenditures on conversion, renovation and construction of new physical resources be directed, where practicable, toward the provision of those categories of facilities (e.g., ambulatory, convalescent and chronic) for which there appears to be a greater need and which are less expensive to operate than acute care facilities.

RECOMMENDATION 18
THAT, in districts where small hospitals are ineffective and inefficient, they be consolidated into single units or converted and used for a more appropriate level of health care. The acute care functions of the small hospitals might be replaced with facilities for ambulatory care and support services.

RECOMMENDATION 19
THAT studies be made relating to the provision of less costly alternatives to in-patient care in active treatment hospitals and that insurance and other mechanisms be adjusted so as to remove incentives for the use of in-patient care in active treatment hospitals while arranging for incentives for other types of care.

RECOMMENDATION 20
THAT studies be made of hospital costs to suggest ways by which operational efficiency and economy of hospitals can be improved. Included might be studies related to alternative payment mechanisms for

services, to management practices which stress cost effectiveness, to the provision of incentives which reward high quality and economical practices by hospital personnel and to alternative methods for handling food, laundry, purchasing and other supporting services which might be shared advantageously by several institutions or eliminated from the hospital plant.

RECOMMENDATION 21
THAT utilization of beds now available in active treatment hospitals be increased by providing regular medical and diagnostic services on weekends, holidays, and in the evenings, recognizing the need to balance the increase in immediate operational cost against the long-term savings which would ensue from reduced bed requirements.

RECOMMENDATION 22
THAT acute care hospitals be considered as part of the spectrum of health facilities for the community and that a concerted effort be made to restrict admission or retention of patients in active treatment hospitals to those requiring the special services only available in active treatment hospitals and that mechanisms be established in the community to ensure the prompt transfer of patients to other types of facilities and services when they no longer require the services of an active treatment hospital.

RECOMMENDATION 23
THAT community hospitals of appropriate size and under certain circumstances make provision for medical personnel based full time on the premises to assist in the direction and administration of clinical services, to encourage better ambulatory and emergency services at the hospital, and to establish a base on site for urgent consultation and for continuing education. Accommodation for this purpose should be provided.

REHABILITATION SERVICES
(See also Comments in Appendix A, Part I, 91-95)

Conclusions

26. The field of rehabilitation services represents in microcosm the major problems which plague the present pattern for the delivery of health care in general.

27. There is lack of adherence to the superficially defined goal of assisting the handicapped to achieve, or be restored to, optimal function. Strongest emphasis is on physiotherapy, with little attention to the role of rehabilitation in respiratory, cardiac and other disorders, and too little use of social, vocational, and educational approaches to rehabilitation. In addition, the active and rehabilitation phases of treatment tend to be separate and sequential, rather than concurrent, and continuity of rehabilitation services is not always provided from the hospital to the long-term care institution, home care, ambulatory and sheltered employment situations.

28. The shortage of services is compounded by ineffective use of a relatively small number of specially trained professional personnel. Their services must be made to go as far as possible; they must act in an integrated manner, and should perform a consulting role, within the hospital system, and to voluntary agencies and special interest groups. The isolation of rehabilitation therapists must be overcome, so that treatment is not restricted to selected patients, and so that the general approach of the practising profession may be influenced through continuing education.

29. There is a lack of overall co-ordination of the aims and efforts of the various provincial departments and agencies and among voluntary organizations concerned with these services, with a resulting fragmentation, imbalance or duplication of programmes.

30. The location of rehabilitation services should be closely integrated with other aspects of the delivery of physical and mental health care. Regional centres should be the base for mobile consulting teams who could provide specialized services to hospitals, domiciliary institutions and voluntary agencies throughout the region. Each regional centre should be affiliated

with a health sciences centre to facilitate educational programmes for the several health professions, and to stimulate evaluation of current practices, research and innovation.

Recommendations – Rehabilitation Services

RECOMMENDATION 24
THAT the scope of rehabilitation services be defined to include social, psychological, educational, and vocational aspects as well as physical rehabilitation.

* *RECOMMENDATION 25*
THAT the programmes and planning of the several governmental departments and voluntary health agencies concerned with the broad aspects of rehabilitation be co-ordinated by the establishment of a broadly representative advisory committee, with primary responsibility for co-ordination resting with the Minister of Health.

RECOMMENDATION 26
THAT general rehabilitation services be accommodated in active treatment, convalescent, and chronic disease hospital units, with emphasis on the extension of these services into the ambulatory, domiciliary, and home setting, and also on the avoidance of isolation of these services from the general practice of medicine.

RECOMMENDATION 27
THAT regional rehabilitation units to serve both in- and out-patients be established as centres for referral of patients with severe, prolonged or unusual disabilities, and to serve as a repository of specialized resources to be used in support of the general rehabilitation units of the region and the needs of voluntary health agencies. To facilitate educational and research programmes, the regional units should be affiliated with university health sciences centres.

CONVALESCENT CARE FACILITIES
(See also Comments in Appendix A, Part I, 102-105)

Conclusions

31. The present policy of the O.H.S.C. to have specially designated beds for convalescents only in certain existing special institutions and in conjunction with regional rehabilitation facilities or principal district centres results in inappropriate and costly care. Large numbers of convalescent patients are occupying active treatment hospital beds who could be in more appropriate facilities specifically designed and staffed for the purpose and characterized by substantially lower operating costs.

32. Since convalescent patients may require many of the services and facilities available in the active treatment hospital, special convalescent facilities should ordinarily be located in close conjunction with such a hospital. The needs of many convalescents overlap with those of the chronically ill; therefore, it is logical to relate convalescent facilities rather closely to chronic care facilities. A common and insufficiently stressed need, for example, is that for appropriate rehabilitation services.

33. Early and consistent discharge planning for all patients admitted to active treatment hospitals would lead not only to earlier transfers to less costly, alternative forms of institutional care but also to transfers to home care when essential follow-up services could be provided in the home. Close professional liaison is needed between the active service of a hospital, convalescent-rehabilitation facilities, and home care services.

34. In overall hospital planning in Ontario, beds for convalescence are generally merged with active treatment beds in combined bed-population ratios. While it is logical for certain short-term convalescent patients to remain in active treatment beds until discharge, there would be planning and operational advantages beyond operating cost and perhaps capital cost savings in separating most convalescent beds from active treatment beds. Lower and more accurate active bed ratios would emerge as reporting and planning tools and a net reduction in bed requirements might well result from speeding up the space of scheduling services and discharging patients from units which could be more active in fact as well as in name.

Recommendations – Convalescent Care Facilities

RECOMMENDATION 28
THAT in the future, appropriate facilities for convalescent patients be established in or in conjunction with active treatment hospitals. The provision of these facilities should be based on studies of the desirable overall ratio of convalescent beds to populations of varying compositions, of the crossover points of cost and effectiveness as between hospitals which should and those which should not provide special convalescent facilities, and of the best way to provide such facilities in communities with more than one hospital.

RECOMMENDATION 29
THAT early hospital discharge or transfer planning, and strengthened liaison between appropriate components of the functional spectrum of facilities for health and social services, be promoted by regulation, through governmental consultative services, through voluntary accreditation processes, or by other means.

CHRONIC CARE FACILITIES
(See also Comments in Appendix A, Part I, 112-116)

Conclusions

35. Substantial progress has been made in Ontario towards achieving what appears to be a minimal goal in providing special facilities for chronically ill patients. Although certain districts lack such facilities, there is generally speaking a reasonably even distribution of special facilities over the province–in chronic hospitals, in special units in active treatment hospitals, and in certain nursing homes temporarily approved by the O.H.S.C.

36. Despite substantial achievement of what has been the goal, 1 chronic bed per 1,000 population, there is evidence from various sources that this goal is not high enough. Insufficient provision of chronic care beds is resulting in inappropriate care for large numbers of patients who are "dammed back" in costly active treatment beds or in nursing homes, homes for the aged, and various charitable institutions.

37. It appears that activation programmes are receiving insufficient emphasis in many chronic care facilities and that policies are needed to promote the kinds of services that can reasonably be provided at community, district, and regional levels.

38. A substantial proportion of extended care is now being given in certain sections of the provincial mental hospitals to patients who have both chronic and psychiatric disabilities, and they should receive the same standard of care as patients in other chronic care facilities.

39. The provision of a more adequate supply of chronic care beds should result in lowering somewhat the requirements for active treatment beds and for beds in domiciliary care facilities of the various types.

40. Certain factors other than the availability of beds impede the flow of appropriate patients to chronic care facilities, e.g., the problem of readmission to a private nursing home after temporary transfer to a chronic care facility, the lack of professional resources for careful assessment and placement of chronically ill patients, and the lack of effective liaison between components of the health care system.

Recommendations – Chronic Care Facilities

* *RECOMMENDATION 30*
THAT more adequate provision be made for special facilities for the chronically ill, generally in conjunction with active treatment hospitals, and that in the provision of chronic beds the social advantages of wide distribution of such facilities be kept in mind, subject to the maintenance of approved standards of activation and other services and to easy transferability of a patient between the community, district and regional levels.

RECOMMENDATION 31
THAT the sections of the provincial mental hospitals presently providing care for patients with both physical and psychiatric disabilities be recognized in the same general category as chronic care hospitals and service provided according to the same standards.

RECOMMENDATION 32
THAT revised bed-population ratios as planning standards for chronic care facilities (and related alternative facilities) be arrived at through studies, recommended elsewhere in this report, related to levels of care requirements of all segments of the population of Ontario.

* *RECOMMENDATION 33*
THAT professional patient assessment teams be organized in district and regional chronic care facilities to serve not only the needs of the medical staff and patients of the institution but to be a resource as a referral centre for the area for the assessment of geriatric, physically and mentally chronically ill, and other appropriate patients, and their recommended placement in a variety of extended care or domiciliary facilities or under a comprehensive home care programme.

RECOMMENDATION 34
THAT improved liaison between chronic care units and other appropriate components of the functional spectrum of facilities for health and social services be promoted by regulation, through governmental consultative services, through voluntary accreditation processes, or by other means.

NURSING HOMES
(See also Comments in Appendix A, Part I, 132-138)

Conclusions

41. Although nursing homes represent an essential element in the spectrum of health facilities, ideally providing "intermediate care" of good quality, their development in Ontario has been almost entirely unrelated to overall health care planning. Their private owners have been able to establish nursing homes where they saw fit and of any size, and until very recently, with little reference to defined standards of care. Aside from those facilities temporarily approved by the O.H.S.C. for the chronically ill and those designated as Homes for Special Care, nursing homes admit

a wide variety of patients and residents, depending on the admission policies preferred by their proprietors, often having the sort of mixture of patients that makes maintenance of high quality standards almost impossible.

42. There is a serious problem of attaining and maintaining adequate standards of care in nursing homes, including standards relating to nursing care, professional nursing supervision, medical supervision and care, nutritional standards, and activation and social services. The numerous very small homes face the greatest obstacles in maintaining standards. Although the Department of Health's new regulations for nursing homes were issued in 1967, by the end of 1968 only three nursing homes had been granted a permanent licence acceptable to the Department, while the provisional licences of the other 462 homes testify to the persistent gaps between minimum standards and performance. The picture is complicated by the alleged lack of special training of nursing home inspectors and uneven enforcement of regulations.

43. There is a lack of co-ordination of nursing home services with other community health services such as those of hospitals and chronic care facilities. Moreover, although approximately 60 per cent of all occupants of nursing homes receive support through provincial or municipal agencies, economic implications often impede the free flow of patients between facilities of various types, e.g., between hospitals and nursing homes.

Recommendation – Nursing Homes

✻ *RECOMMENDATION 35*
THAT long-term governmental policies be formulated, based on such studies in depth as may be required, dealing with domiciliary health care facilities and services in Ontario in respect to such aspects as the following:

a. the respective responsibilities and roles of public, non-profit, and private agencies in providing and operating "intermediate" care facilities;

b. the problem of financing "intermediate care" in such a way as to ensure that adequate, high standard nursing and related services are available

to all who need them, including study of the feasibility of identifying the health care component of the total costs of care, separating it out from the basic costs of maintenance, and having this health care cost borne through provincial health insurance financing mechanisms (a technique which might be applicable as well to care in other long-term domiciliary care institutions, foster homes, and even the patient's own home).

RECOMMENDATION 36
THAT consideration be given to subdivision of licensing of nursing homes, with a particular licence being geared to a particular level of service; and further, that a change of policy be considered whereby homes offering primarily non-health-related service to largely self-sufficient persons would be licensed and supervised but would no longer be designated as nursing homes.

* *RECOMMENDATION 37*
THAT the whole process of enforcement of nursing home regulations, licensing, and supervision be greatly strengthened and applied in a more uniform manner by involving the Medical Officers of Health more fully, by instituting special training programmes for nursing home inspectors, and by assuring all concerned of complete government backing as they carry out a difficult and sensitive assignment.

RECOMMENDATION 38
THAT the Department of Health lend its full support to various voluntary efforts to upgrade the knowledge, skills, and training of administrative personnel of nursing homes, as well as issuing regulations requiring stipulated qualifications for administrators by a certain date.

RECOMMENDATION 39
THAT, when regional and district health councils are established, their delegated responsibilities include planning for the provision of adequate nursing home facilities and a review and approval function with

respect to private proposals for the establishment of nursing homes, and further, that at the provincial level current informal co-ordination efforts be replaced by formal, consistently used co-ordinating mechanisms to assure that nursing home policy matters will receive joint consideration by the Department of Health, the Department of Social and Family Services, and the Ontario Hospital Services Commission. Primary responsibility for co-ordination should be assigned to the Minister of Health.

HOMES FOR THE AGED, REST HOMES, AND CHARITABLE INSTITUTIONS
(See also Comments in Appendix A, Part I, 150-153)

Conclusions

44. The Department of Social and Family Services appears to be making good progress in setting standards, collaborating in the provision of facilities for differing levels of domiciliary care, extending consultative services, and fostering educational programmes for administrators, physicians, and others serving the various institutions.

45. The new programme of developing public high standard Rest Homes for incapacitated, bed-ridden, and severely handicapped persons of various ages is a promising one, first, because accommodation will be assured for those seriously disabled persons who often cannot gain admittance to nursing homes because of the amount of care they require, and second, because the programme will tend to free up bed care areas of Homes for the Aged, allowing them to meet more adequately the needs of largely self-sufficient persons who require domiciliary care. The extension of this public domiciliary care programme, moreover, will facilitate the earlier discharge of many patients from hospitals and chronic care facilities, with resulting economies. It must be noted, however, with this quite promising forecast, that at this time development of new Rest Homes is held up by provincial financial stringencies.

46. Although the domiciliary care institutions under the jurisdiction of the Department of Social and Family Services have definite

health service elements, their planning has been co-ordinated with the health care planning of the O.H.S.C. and the Department of Health only on an informal basis.

Recommendations – Homes for the Aged, Rest Homes, and Charitable Institutions

* *RECOMMENDATION 40*
THAT, with a view to achieving the most effective and comprehensive health care planning, there be formal, consistently used planning co-ordination mechanisms involving the Department of Health and the O.H.S.C. along with the Department of Social and Family Services (e.g., establishment of a senior level interdepartmental committee required to meet and report regularly to officials at the Deputy Minister level). Similarly, both health and welfare interests should be involved, at district and regional levels, in planning all types of domiciliary care having a health care component, with primary responsibility for co-ordination assigned to a specific Minister.

* *RECOMMENDATION 41*
THAT the Province be urged to set a high priority for the programme of Municipal Rest Homes.

COMPREHENSIVE HOME CARE PROGRAMMES
(See also Comments in Appendix A, Part I, 167-168)

Conclusions

46. The home of the patient, under acceptable conditions, is the ideal "physical resource" for the acute and chronic illness. Cumulative data on the thousands of beds in health care institutions of a score of different kinds in Ontario reinforce the disquieting recognition that we are over-institutionalizing our population and are far from fully exploiting the use of the patient's home.

47. While substantial progress is being made in Ontario, under the leadership of the O.H.S.C. and the Department of Health, organized home care services are still lacking in many

jurisdictions and the programmes are coping mostly with the visible part of the iceberg where they do exist.

48. It is possible that unnecessary rigidities in approach to organizing these programmes, including their proposed fractionation between agencies, are retarding their expansion and broadening, and that acceptance of the logic of considering home care services as an integral part of community public health programmes would greatly accelerate the whole development.

Recommendations – Comprehensive Home Care Programmes

RECOMMENDATION 42
THAT there be a reassessment of the current pattern of organization of home care programmes in Ontario, with participation by appropriate consultants, to determine whether the present approach is the most effective possible and in particular to advise on the desirability of incorporating administrative responsibility for comprehensive home care programmes among the recognized responsibilities of local Departments of Health and of eliminating what appears to be the unnecessary and undesirable split between Home Care (Treatment Services) and Home Care (Services and Supervision).

RECOMMENDATION 43
THAT co-ordinated home care programmes organized in accordance with approved patterns be extended throughout Ontario as rapidly as possible and that they be aided in all possible ways to achieve their full potential in meeting needs.

COMMUNITY HEALTH CARE FACILITIES FOR AMBULATORY PATIENTS

(See also Comments in Appendix A, Part I, 187-207)

Conclusions

49. Reductions in various forms of institutional care would be facilitated if planning were directed to developing a co-ordinated network of appropriate ambulatory care facilities through which

essential services could be provided efficiently, effectively, and economically. Among other things this would involve:

a. consideration of various levels of service, e.g., preventive, health maintenance, care for acute episodes of illness or accidents, and intermittent care on a continuing basis;

b. consideration of various locations of existing or proposed facilities, e.g., the home, the hospital or its "campus," other health care or related institutions or their environs, the public health centre, the school, the industrial plant, and the community at large;

c. participation of regional and district health councils, as well as Provincial Government departments, in integrating this largely neglected area into over-all planning of health services and facilities;

d. accommodation to the interests and rights of independent practitioners of the healing arts and other involved persons, organizations, and institutions;

e. consideration of the degrees of governmental responsibility involved in respect to the capital costs and operation of various facilities.

50. Certain trends and forces are operative currently which would strengthen and augment developments in the direction of building a more rational system of personal health care. Among these are:

a. growing discontent among people generally with the fragmentation and often sheer unavailability of health care, a feeling which is intensified by rising levels of education, standards of living, sophistication in health matters, and health insurance coverage;

b. a steadily increasing tendency of people to turn for help to such organized centres of care as the community hospital and the medical group;

c. the rapid expansion of medical group practice, influenced by specialization, manpower shortages, the 40-hour 5-day week, and other factors;

d. the growing acceptance of the concept of the health team, with delegation of responsibilities by certain professionals to others and in turn to non-professionals;

e. increasing realization by hospitals, departments of health, professional societies, universities and others that revisions of programmes to meet today's and future needs is overdue.

51. Medical group practices offer many advantages to the families served and to those physicians and other health personnel who can work comfortably in an organized setting. The establishment of a variety of group practices geared to meeting particular needs, based in efficient modern facilities, should be encouraged. Illustrations of varying patterns in different situations would include:

a. the large multi-disciplinary group comprising family physicians and specialists based on a teaching hospital or on a district or major community hospital, with access to hospital diagnostic and therapeutic resources for ambulatory patients, and with staffing encompassing a whole range of professional and technical collaborating and supporting staff in fields such as clinical and public health nursing and social work. To the extent that the hospital's resources could not be used to mutual advantage, the staff could include physiotherapists, occupational therapists and other professional and technical personnel. The group could be further strengthened by including dentists and dental auxiliary personnel.

b. the family service group in an urban neighborhood, desirably an integral part of or affiliated with the sort of group described in (a), comprising family physicians and full-time or part-time consulting specialists in internal medicine, paediatrics, psychiatry, and OB-GYN, with public health oriented nursing staff, social work assistance, basic x-ray and laboratory services, etc. There might be a network of several such group centres affiliated with a health sciences centre and its teaching hospital, serving residential neighborhoods, major housing developments, particular poverty areas, and so on. Location of a centre next to a chronic hospital or nursing home could influence favourably the quality and availability of services in the institution;

c. the group based on a district or principal community hospital

in a predominantly rural area, comprising family physicians and a variable range of those specialists who are hard to attract to such locations except as members of a group, e.g., an internist, a paediatrician, possibly a psychiatrist, and an OB-GYN specialist, as well as one or more general surgeons;

d. the group like the one described in (c) but with less extensive specialist staffing, which would serve a community and area which could not support a hospital of desirable size but could well support a medical care centre offering many of the advantages of an active treatment hospital without its hotel component. Such a centre, which might be established in conjunction with a public health centre, could include nursing, physiotherapy, technical and clerical personnel; maintain basic laboratory and x-ray services, and facilities for dispensing drugs; and provide emergency care. It could maintain an active link by transportation and communication with a general hospital in the district at which the group physicians should have staff privileges.

52. Medical group practices vary in sponsorship. Ordinarily they are sponsored by physicians, but occasionally by an industry, a labour-management welfare fund, or consumer or community groups. Participation by community and consumer leadership representatives at the overall policy level, in "partnership" with the providers of service, has demonstrated its usefulness, with results in such non-profit settings showing up in emphasis on preventive services and on ambulatory care in general and in reductions in hospitalization and surgical procedures. In consumer-sponsored programmes, responsibility for the capital costs of facilities typically rests with the consumer organization, while net income for services rendered goes to participating doctors as salaries or other variations of partnership income.

53. The organized out-patient department, which has evolved from the 18th century dispensaries for the sick poor, has largely outlived its usefulness even in the teaching centres. With universal coverage medical services insurance on the near horizon in Ontario, all patients will rapidly become private patients. As such they should, if they wish, have personal or family physicians who care for them on a continuing basis and mobilize such consultant or other services as may be required. Under these circumstances, the multiple clinic O.P.D., with its heritage of hard benches, long waits and impersonality, should quickly transform itself into an

appropriate form of medical group practice based in or adjacent to the hospital, with at least some of the physicians on a "geographic full-time" basis.

54. Hospital emergency services for the most part have failed to meet the increased demand with prompt, sympathetic and high quality medical services. The care of medical emergencies, moreover, is compromised to an increasing degree by the rising tide of patients with non-urgent complaints who now flood hospital emergency rooms seeking primary medical care. There is a need to introduce measures such as triage with appropriate action or referral, back-up staffing by specialists of several varieties, and improved ambulance services including two-way communication between ambulance and hospital. It would be desirable to integrate emergency service staffing with a hospital-based group practice which would assume responsibility for proper handling or referral on non-urgent cases after triage, as well as true emergency cases. Ambulance and emergency services should be planned and organized on an overall regional and district basis, and emergency departments should be expanded or otherwise revised as required to meet today's needs.

55. Current school health practices call for minimal physical facilities such as office space and first-aid facilities. A few schools make some provision for preventive dental care, a service which would require augmented special facilities if organized school dental services were made generally available. Some educational institutions such as certain universities find it appropriate to maintain well staffed and equipped infirmaries.

56. Certain large industries maintain adequate facilities and staff to provide the full scope of current occupational health practices. There are gaps in such services, however, some of which—involving small plants—could be filled through the co-operative sharing of the time of nursing and medical personnel and the provision of minimal facilities or use of a shared mobile unit.

57. It is a cliché to talk of getting the health department out of the courthouse basement, but the fact is that the community's basic programme of prevention and health promotion seldom finds recognition in a well-planned, attractive community health centre. Such centres are needed for many reasons, including enforcement of the point that public health services are for everyone and not just for the poor. Community health services

can be strengthened, moreover, when combined centres furnish facilities for key voluntary health agencies as well as the official agency.

Recommendations – Community Health Care Facilities for Ambulatory Patients

RECOMMENDATION 44
THAT the Province recognize the human values and the potential controls over rising health care costs which would result from placing new emphasis on the planned provision of adequate health care facilities for persons living independently in the community outside of institutions, i.e., so-called "ambulatory care facilities."

RECOMMENDATION 45
THAT responsible health planning bodies at all levels—notably provincial, regional, and district—accept the concept that a co-ordinated network of health facilities and services can be complete and effective only by encompassing, as an integral part of the network, the facilities and services needed by the vast majority of the population who are not in health care or health related institutions.

* *RECOMMENDATION 46*
THAT in developing health resources, the Province give priority to extending financial assistance to public and non-profit agencies for a range of ambulatory care facilities and services designed to promote health, to prevent disease, and to deliver essential health care in the community. These would include:

a. renovated and revised hospital emergency and out-patient facilities to meet changing needs, planned to facilitate the provision of dignified, responsible care preferably provided through organized professional group action which should generally involve the participation of at least some physicians on a geographic full-time basis;

b. community health care centres which would provide diagnostic and treatment facilities for groups of physicians, nurses, and other health

workers, whose efforts would be directed at the delivery of health care in the community. In certain rural areas, centres of this kind could replace small, inadequate hospitals or meet needs without the establishment of such hospitals. In urban areas they could supply primary medical care in natural neighbourhoods including those of low income, those comprising major housing developments, etc. In both types of setting they could be sponsored in various ways, e.g., by municipalities, a health district, a nearby hospital, a co-operative or other non-profit organization, or by a teaching centre for the health professions;

c. community public health centres to provide service and educational facilities for organized community health activities. Official and voluntary health agencies might well collaborate in establishing combined centres. Useful collaboration between public health and clinical personnel in meeting community needs might be achieved by combining a community public health centre with a community health care centre, particularly in rural or problem communities.

MENTAL HEALTH FACILITIES
(See also Comments in Appendix A, Part II, 58-77)

Conclusions

58. As Psychiatry is a specialty of Medicine, psychiatric services should presumably be organized to reinforce and complement other health services.* If this premise is accepted then psychiatric

* It is noted that Government services tend to use "Mental Health" as a euphemism for psychiatric services and, on the other hand, that university medical schools, general hospitals, medical and hospital care insurance programmes tend to speak of psychiatric services. As Psychiatry is a special branch of medicine concerned with the investigation, treatment and rehabilitation of psychiatric disorders, it is recommended that psychiatric treatment services be administered under the heading of "Psychiatric Services" rather than "Mental Health Services." Mental Health Services is meant to indicate a more comprehensive programme which would include (a) a control programme for mental illness made up of detection, treatment and rehabilitation together with psychiatric services, (b) a programme for the prevention of psychiatric disorders and the promotion of better mental health.

services should be organized with this in mind and the following levels of service should be provided to complement the total health serivce: (a) consultation and out-patient or ambulatory care; (b) emergency care; (c) in-patient care; (d) special regional facilities; and (e) province-wide facilities.

Consultation and Ambulatory Care

59. Case consultation should be available to front line personnel, of which the personal or family physician will be the most prominent, but should also be available to public health nursing, social agencies, school systems and so on. As vertical integration and horizontal communication are essential to this development, case consultation should be provided and organized as is case consultation in any other field. On the other hand, essential programme and community services consultation should be an integral part of the public health programme of the community. The provision of consultation service does not require any special psychiatric facilities but does require office space for the specialist and other personnel involved in such a service.

Emergency Care

60. The second level of service required is for the acute care of disturbed persons. It should be emphasized that the acute care of patients with psychiatric disturbances is not particularly difficult. This is mainly a matter of medical management and nursing care rather than of facilities. Every general hospital should be able to admit a disturbed patient as it would an accident case, and should be able to provide treatment as it would for surgical shock. The suggestion that each general hospital should be able to care for psychiatric emergencies has, therefore, very few implications in terms of physical plant.

In-Patient Care

61. Local general hospitals must be supported by psychiatric units in appropriate general or special hospitals in the various districts and regions of the province. Through such arrangements it will be possible for patients, who have received the first and second level of treatment, to be appropriately investigated and referred to further necessary treatment either in the community or at a more highly specialized psychiatric service.

62. Of great importance here, in order to prevent the "silting up" of the psychiatric unit, is the relationship of the hospital and medical services in general to other personal care services in the community, particularly those presently under the jurisdiction of welfare (e.g., housing and financial and social support).

Special Regional Facilities

63. The region should contain the more highly developed psychiatric facilities, either located in the regional general hospitals or in existing special regional facilities. Included in these regional services would be special services for the continuing investigation and care of geriatric cases and adolescent patients, the investigation and programming for emotionally disturbed children and the mentally retarded.

64. In particular, a group of conditions best described as psycho-social, including adolescent and adult anti-social behaviour, alcoholism, drug abuse, old age, need to be given special consideration and further studies will be necessary before effective programmes, rather than removal to an institution, can be started.

Province-wide Facilities

65. Certain very highly specialized services should be provided for the entire province. At this stage in Ontario, it is doubtful that any services, other than those for the criminally insane and the dangerous mentally ill, should be on a province-wide basis.

66. The planning of a highly centralized system of psychiatric services based on the present four planning areas (a relatively small central area surrounding Toronto and areas in eastern, western and northern Ontario) is questionable. Despite past experience, planning should be decentralized and the growth of service should be from the local level upwards rather than being developed and imposed by the central authority.

67. The desirability of the mental health programme fitting into the pattern of regionalization being developed for other health services should be stressed. Facilities for the physically and the mentally ill could be integrated, or at least brought into closer relationship. Through a system of regionalization, more effective use could be made of available personnel and financial resources.

68. Where psychiatric services exist in separate facilities, responsibility for their operation should rest with local boards similar in type to those established for public general hospitals. This type of community participation is basic to the concept of regionalization.

69. The type of programme envisaged in this report would require effective integration of psychiatric services in all health department activities at the provincial, regional, and district levels. This integration would require psychiatric consultants attached to the various agencies and groups responsible for health in the province, rather than a separate Division of Mental Health.

70. The financing of the operation of mental health and psychiatric services and the related capital grants system should be integrated fully into other health care programmes.

71. While the Committee has not had an opportunity to give detailed consideration to the subject of facilities for children with emotional disorders, it would appear that, while there are a great many diagnostic services developing throughout the province, there is a great deal of difficulty in obtaining treatment for such children. The varying responsibilities of health, education, welfare, reform institutions, and justice departments, would appear to compound the difficulties at the local level in particular, and the increasing separation of child psychiatry from the mainstream of medical services and even child psychiatry from paediatrics is likely to lead to further confusion throughout the community. While there is great demand for special services for these children and while such projects as the establishment of a Children's Services Branch in the Mental Health Division may appear to have many immediate advantages, it is felt that in the long run this will not constitute the most effective way of approaching the problem.

72. The provision of psychiatric units in public general hospitals may not meet the service needs of the community as long as private practitioners of psychiatry using these facilities are not required by the hospitals to accept the full spectrum of responsibilities of community mental health care. The use of these units, therefore, should be functionally integrated with the regional health centres responsible for mental and physical health care, in terms of prescreening procedures, special consultation with community agencies, crisis intervention, and other functions which may not fit into the classical model of private practice.

73. In connection with the problems of alcoholism and drug abuse it is recognized that the Alcoholism and Drug Addiction Research Foundation has important contributions to make in research and in public education. In view, however, of the nature and extent of the problems it is not desirable or practical to separate treatment programmes from the mainstream of health services, education and research, or to develop facilities for these purposes in isolation.

Recommendations – Mental Health Facilities

* *RECOMMENDATION 47*
(same as Recommendation 2)
THAT services and facilities for the mentally ill and for the retarded be planned, operated and financed within the context of general health services, and that the role of the Department of Health be redefined now with a view to,

a. integrating the psychiatric treatment services with all other treatment services;

b. integrating those activities designed to promote better mental health and to prevent psychiatric disorders throughout the province with the total effort of this nature in the Department; and

c. integrating the financing of capital and operating costs for adequate psychiatric and mental health services to provide comparable standards of care with other health care programmes. The same principles should apply.

* *RECOMMENDATION 48*
THAT psychiatric and mental health services be integrated with the pattern of regional organization being recommended for all health services. The regions should contain the more highly developed psychiatric facilities either located in general hospitals or special regional facilities. Included in these special regional services would be facilities for the continuing investigation and care of geriatric cases, adolescent patients and the investigation and treatment of emotionally disturbed children and the mentally retarded.

RECOMMENDATION 49
THAT, to ensure community participation, local boards be established and made responsible for the operation of separate mental health facilities in a way similar to that in effect for public general hospitals.

RECOMMENDATION 50
Incorporated in Recommendations 2 and 7.

* *RECOMMENDATION 51*
THAT efforts be made to ensure that every general hospital is able to care for psychiatric emergencies, since it has been amply demonstrated that, given adequately trained staff and arrangements for care after the acute episode, the general hospital should be able to admit such patients as it would other emergency cases.

RECOMMENDATION 52
THAT a review should be made of the standards, indices, methods and procedures involved in the planning of mental health facilities, including: the standards related to facility location and bed needs, the methods used to identify the need for new types of facilities, the establishing of priorities and the planning process involved.

RECOMMENDATION 53
*THAT psychiatric and mental health services for children be integrated with and developed in collaboration with psychiatric and general health services for adults and children. (Decision deferred.)**

RECOMMENDATION 54
THAT psychiatric units in public general hospitals be fully integrated with appropriate community services and that private practitioners of psychiatry using the facilities of the units be encouraged to provide community consultation services.

* Council reserved judgment on Recommendation 53 pending receipt, discussion and consideration of a comprehensive background document on the whole issue of separate health care facilities for children.

RECOMMENDATION 55
THAT, while recognizing the important contribution that the Alcoholism and Drug Addiction Research Foundation has to make in public education and research, its operation of facilities for treatment at the local level be integrated with the mainstream of health services, education and research.

HEALTH FACILITIES IN RELATION TO EDUCATIONAL AND RESEARCH PROGRAMMES
(See also Appendix A, Part III, 1-15)

Conclusions

74. Expanded facilities are required to cope with the increased demands for education at all levels of health personnel and for the accommodation of balanced programmes of fundamental, applied, operational and developmental research.

75. Major responsibility for these programmes rests with university health sciences centres but certain types of professional and technical education may be assigned with advantage to colleges of applied arts and technology. Health training programmes should normally be restricted to colleges of applied arts and technology, where they are located in close geographic proximity to a university health sciences centre, and on-going working relationships established between the two types of educational institutions with respect to these programmes.

76. Supervized clinical experience is the cornerstone of educational programmes for the health professions. Special programmes of education and research in the health sciences should be established in relationship to the regional network of specialized health services for the geographic area in which the health sciences centre is located.

77. The current delay in financial approval of facilities to accommodate teaching and research programmes for the health sciences represents a serious threat to a future system for the delivery of health services from the standpoint of quality, quantity and distribution. A major capital investment now in university health sciences programmes is justified on the basis of

the long-range benefits in augmenting the supply of health manpower, catalyzing regional planning of specialized health services, shaping new approaches to the delivery of health care and influencing the quality and economy of health services through applied and operational research.

78. Planning of health sciences facilities could be placed on a more rational basis if the resources required are related to the responsibilities assumed, and roles of the university and affiliated health facilities accurately defined. Instead of increasing involvement with active treatment hospital beds, universities should look to ambulatory and chronic care facilities to a greater extent as a preferable environment for some of the training programmes.

79. The population in Northern Ontario should not be deprived of potential advantages of affiliation with university health sciences programmes.

Recommendations – Health Facilities in Relation to Educational and Research Programmes

RECOMMENDATION 56
THAT provision be made in health care facilities of appropriate type for undergraduate, postgraduate and continuing education of health personnel in programmes directed by universities, colleges of applied arts and technology, and regional schools and hospitals.

RECOMMENDATION 57
THAT the current trend to bring together educational programmes for several health professions in health sciences centres be encouraged as a means of increasing collaboration among the health professions and evolving more effective methods for the delivery of health care through sharing of responsibility and through operational research.

RECOMMENDATION 58
THAT the special clinical resources and higher unit costs associated with health facilities which accommodate clinical training and research programmes be accepted as a recognized cost related to

the provision of health manpower and the improvement of the quality of health services.

RECOMMENDATION 59
THAT educational programmes for the health professions be organized in relation to the general and special health services and programmes of the district or region in which the educational centre is located, and that those responsible for the education of the health professions be represented on district and regional health councils responsible for area-wide planning and co-ordination of health resources.

RECOMMENDATION 60
THAT applied clinical and operational research be developed in balance as an integral function of all major health facilities used for teaching purposes and that research space and equipment be provided to achieve this objective.

RECOMMENDATION 61
THAT in the planning and construction of new or renovated health facilities, the cost assigned for educational programmes be limited to those components specifically used for teaching and research which would normally not be provided in an institution with comparable responsibility for community health services.

* *RECOMMENDATION 62*
THAT the substantial long-range benefits in health manpower, regional planning, introduction of new approaches to the delivery of health care, and health research, which may be expected to accrue from the growth of university health sciences programmes be recognized by making sufficient capital funds available now for their early development.

RECOMMENDATION 63
THAT if no university health sciences centres are anticipated in the near future in northern Ontario, substitute arrangements for the needs of the area, including the major centres of population, be explored, (e.g., independent unit or affiliation with

one of the health sciences centres in southern Ontario).

PLANNING, DESIGN, AND CONSTRUCTION
(See also Comments in Appendix A, Part IV, 10-14, 20-23, and 26-29)

Conclusions

80. A co-ordinated long-range planning programme for health services and related facilities is lacking in Ontario. The present programmes are characterized by duplications of planning effort, cumbersome review and approval procedures, a lack of co-ordinated planning of facilities on an area basis, all of which lead to the unjustifiable demand on the time of planning specialists and on the time of highly trained health services personnel.

81. The present methods of planning facilities tend to concentrate on over-simplified units of measurement, such as the hospital bed. Measurements presently used are not sufficiently sensitive to changing patterns of health care to form the basis for planning future physical resources.

82. Insufficient emphasis is being placed on the need for flexibility, diversity and expandability of physical plant so that it may be adapted to new programmes and may help to counter rising costs of construction, maintenance and operations.

83. The process of design has become increasingly complex and there are increasing numbers of design consultant specialties which result in a continuing disparity between project plans and the generally accepted ideas of good design. The effects of these changes are complicating and slowing down the planning and design processes for health service facilities in Ontario. In addition, the full potential of advances in design technology is often not used to improve the utility and flexibility of physical plant.

84. Canada is lacking in design information for health service facilities. Ontario, with the other provinces, would benefit greatly with the establishment of a centre devoted to providing information and advice, investigations and research, conferences and meetings, and exhibitions of equipment, etc.

85. While there has been a general rise in building construction and operating costs, the costs for health service buildings have risen at a greater rate. The introduction of group co-ordination on a regional basis could help to offset this rise in costs and bring them more in line with general construction.

86. Insufficient use is being made of research and experience available in new techniques of construction management and systems development, or of the development and general use of mass-produced industrialized system components.

87. Time delays, caused by construction projects not completed by target date, are wasteful of operational funds. Budget allowances should be recognized for the employment of key personnel to bridge the transitional period between final stages of construction, equipping the building and beginning operations.

Recommendations – Planning, Design and Construction

RECOMMENDATION 64
THAT, for all categories of physical resources for health services, the provincial authorities develop guidelines and objectives for each level of planning. This will include long-range master programmes at provincial level, co-ordination of project and programme planning at regional and district levels, and detailed project planning at the level of the individual health facility.

* *RECOMMENDATION 65*
THAT provincial authorities act promptly to expedite the present review and approval process.

RECOMMENDATION 66
THAT the Provincial Government create or assist in the establishment of a Health Facilities Design and Information Centre and that the centre have the following characteristics:

a. be separate from planning and approval agencies and include in its Board of Directors representatives of the several interested disciplines;

b. provide central facilities and nucleus staff for

planning information and advice, a planning library, technical and publication services for investigation and research, space for small conferences and meetings, exhibitions and equipment;

c. *maintain close and cordial relations with government health authorities, with regional organization, with health service, teaching, or research institutions, and with professional associations and research groups interested in planning hospitals and health services;*

d. *be the originator or catalyst of new research and investigation related to the evaluation of development projects, new systems and equipment, and new operational methods, with a view to making information more generally available by means of publications, courses, and audio-video media.*

RECOMMENDATION 67
THAT pre-opening budgets for large or complex health facilities become effective at the appropriate time in the planning of the facility (and certainly before construction begins) and be increased to include a larger number of personnel who will have continuing responsibility for operation of the facility.

Appendix A
BACKGROUND PAPER

CONTENTS

PREFACE

The physical resources of the health and related services in Ontario can be generally characterized as being conflicting and incompletely understood systems related to individual components such as active treatment hospitals, mental health facilities, rehabilitation facilities, nursing homes, homes for the aged, and facilities for ambulatory care. Even within the separated and only loosely related systems, the authorization of new facilities is sometimes at variance with official policies. In order to show the nature and extent of these problems, a review has been made of the current situation. This is not intended to be all encompassing; rather, it highlights some of the difficulties which exist with respect to the components of the present pattern for the provision of health care, and in the overall pattern itself.

To facilitate the description of the present situation, facilities and programmes for physical health and for mental health are considered separately in Part I and Part II respectively. Part III is devoted to the description of health facilities in relation to educational and research programmes, while in Part IV, consideration is given to the planning, design, and construction of health facilities.

Three attachments are included with this Background Paper, providing information as follows:

a. Attachment 1 — a listing of the categories and levels of care used by the Committee as a basis for their considerations;

b. Attachment 2 — a listing of categories of facilities:
   (i) describing the function of each;
   (ii) showing the number of facilities and beds in each category;

c. Attachment 3 — a summary table of agency responsibilities for financing construction and operations of facilities and programmes.

Part I
PHYSICAL HEALTH FACILITIES

SECTION 1

Active Treatment Hospitals

General

1. In Ontario, active treatment hospitals provide care for acutely ill in-patients who require the special facilities of a hospital providing comprehensive diagnostic and treatment services, daily medical attention and reassessment, and skilled nursing care and special techniques. They also provide care to some patients whose condition has passed the acute stage but who continue to require hospital care of a less intensive level than acute.

2. Most active treatment beds are situated in public general hospitals, but private and federal active treatment hospitals also are in operation. Public general hospitals form the backbone of institutional health care. They contain not only active treatment in-patient beds, supporting services such as laboratory and X-ray, and out-patient and emergency facilities for ambulatory patients, but also may contain psychiatric units (classed with active) and convalescent and chronic units. While this section deals primarily with active treatment accommodation and those which follow with the other categories, in some instances, because of limitations of available data, the entire public facility has been included.

3. Public and private hospitals operate under legislation and regulations administered by the Ontario Hospital Services Commission, and most of the care provided in these institutions is covered by the Hospital Insurance Plan. Since the Commission

has considerable authority in connection with hospital planning, construction, and operation, hospital-Commission relationships are also explored.

Quantity, Size and Distribution of Facilities

4. At the end of 1968, a total of 229 hospitals with 38,989 rated beds were classed as active treatment, including 45 intensive care units with 500 beds, and 34 psychiatric units with 1,129 beds. Most of these were public general hospitals, as is indicated in Table 1 on page 72.

5. Many of these facilities are small; almost one-third are under 50 beds in size, and more than 50 per cent are under 100 beds. Most of the small hospitals are in sections of the province where population is not dense, but many of these are within easy driving distance of one another; and even in the same town, two small or medium sized hospitals may be in operation. Only 8 are over 800 beds, and they are in metropolitan areas.

6. Why is size of concern? When compared to larger institutions, small hospitals cannot have such effective staff committees, nor can they provide as comprehensive a range of facilities, supporting services, especially laboratory, X-ray and anaesthesia, and highly trained personnel. They often mean a duplication of facilities and an inefficient use of manpower. Most important, they cannot be expected to provide care of as high quality to as wide a variety of patients, since quality is so closely tied to personnel, to degree of staff organization, and to types of services. Hospitals which are too large, on the other hand, tend to be impersonal, and are often beset by administrative problems.

7. The Ontario Hospital Services Commission has indicated that hospitals of fewer than 50 beds should be built only in rare circumstances of sparse population and excessive distance. It has also indicated that, in metropolitan areas, hospitals should be not less than 300 beds in size and that, in their view, an optimum size is 600 active treatment beds, with appropriately sized chronic and psychiatric units.

Levels of Care

8. Active treatment hospitals provide treatment for not only those who need intensive or acute care. Although this is widely

recognized, the exact amount of non-acute care is not well documented. In a recent one-day study by the Ontario Hospital Services Commission of seven hospitals in downtown Toronto, however, it was found that, of the patients surveyed, approximately one-quarter did not need acute care. The levels of care needed were: intensive – four per cent; intermediate active – 70 per cent; self-care – three per cent; special rehabilitative – two per cent; extended care – 19 per cent; and domiciliary care – two per cent.

9. While the limitations* of this study were stressed by the author, the figures are particularly significant, when it is remembered that the volume of care received by Metro Toronto residents is low–less than 1,300 days of care per 1,000 population.**

Utilization Experience

10. Trends over the past number of years indicate the increasing use which is being made of active treatment hospital facilities. These are shown in Table 2. Most noteworthy are the increases in beds and in days of care per 1,000 population.

11. Comparison of Ontario figures with those of other provinces in Canada and regions in the United States is also of interest. Accurate comparison from area to area is difficult to make, however, because of the different types of facilities which exist, because of the differing policies related to the use of each type, and because of the ways in which practice differs from policy. In the United States, for example, some nursing homes as well as hospitals provide the type of skilled nursing care which in Ontario would be provided in chronic hospitals. Although these differences are not always stressed, they could all cause distortion.

12. In an attempt to minimize such distortion, public and private

* These limitations were that the hospitals were mostly large teaching hospitals with a wide range of services; downtown Toronto is an atypical area; only active treatment beds were surveyed, and these represented only eleven per cent of the total hospital beds in the province, not chosen at random; the sample related to only one day, not chosen at random; and some of the categories of care were unfamiliar to the questionnaire respondants and, therefore, were perhaps used less readily than more familiar terms.

** Based on the population of Metro Toronto and the number of Metro Toronto residents who were separated (discharged or died) from active treatment hospitals, no matter where these hospitals were located.

hospitals offering short- and long-term care have been grouped together. The results are shown in Tables 3 and 4.

13. The ranges in utilization are obvious. Most obvious in comparison to other provinces is Ontario's long average stay, while comparison with the United States reveals that Ontario's admission and days of care rates, and average stay, are higher than they are in almost any U.S. region.

14. Variations in utilization from area to area in Ontario are also significant. The most meaningful index is volume of care, since this rate reflects both number of admissions and average length of stay. The number of active treatment days of care per 1,000 population, by county of patient residence, ranges from 1,200 to 3,000 days. In Figure 2 is shown the pattern of areal differences, based on five categories of volume of care. Most apparent are the lower rates in the vicinity of Metropolitan Toronto and Ottawa, and the higher rates in some rural areas and in Northern Ontario.

15. Many reasons have been suggested for these different rates—the age structure of the population, population density and growth rates, access to service, travel distance, socio-economic factors, patterns and fashions of medical practice, use of active beds for non-acute cases, and the Parkinson's Law relationship between beds available and beds used. But what is really known of these interrelated factors in Ontario? What cognizance should be taken of these in the planning programmes related to the future provision of health services?

16. Utilization rates related to diagnostic categories and based on county of patient residence also reveal interesting differences. Table 11 shows, for the province as a whole and for three counties in Southern Ontario which are similar in population age structure, the cases and days per 1,000 population, and the average lengths of stay for 18 diagnostic categories. As an example, Table 5 lists three categories of noteworthy difference.

17. Again we are left with the question "Why"? It might also be wondered if sufficient use is made by hospital staff of information on utilization rates by diagnostic category. Organizations such as the Commission on Professional and Hospital Activities, at Ann Arbor, Michigan, with its Professional Activity Study programme, and the Hospital Medical Records Institute in Toronto can provide detailed data for medical audit

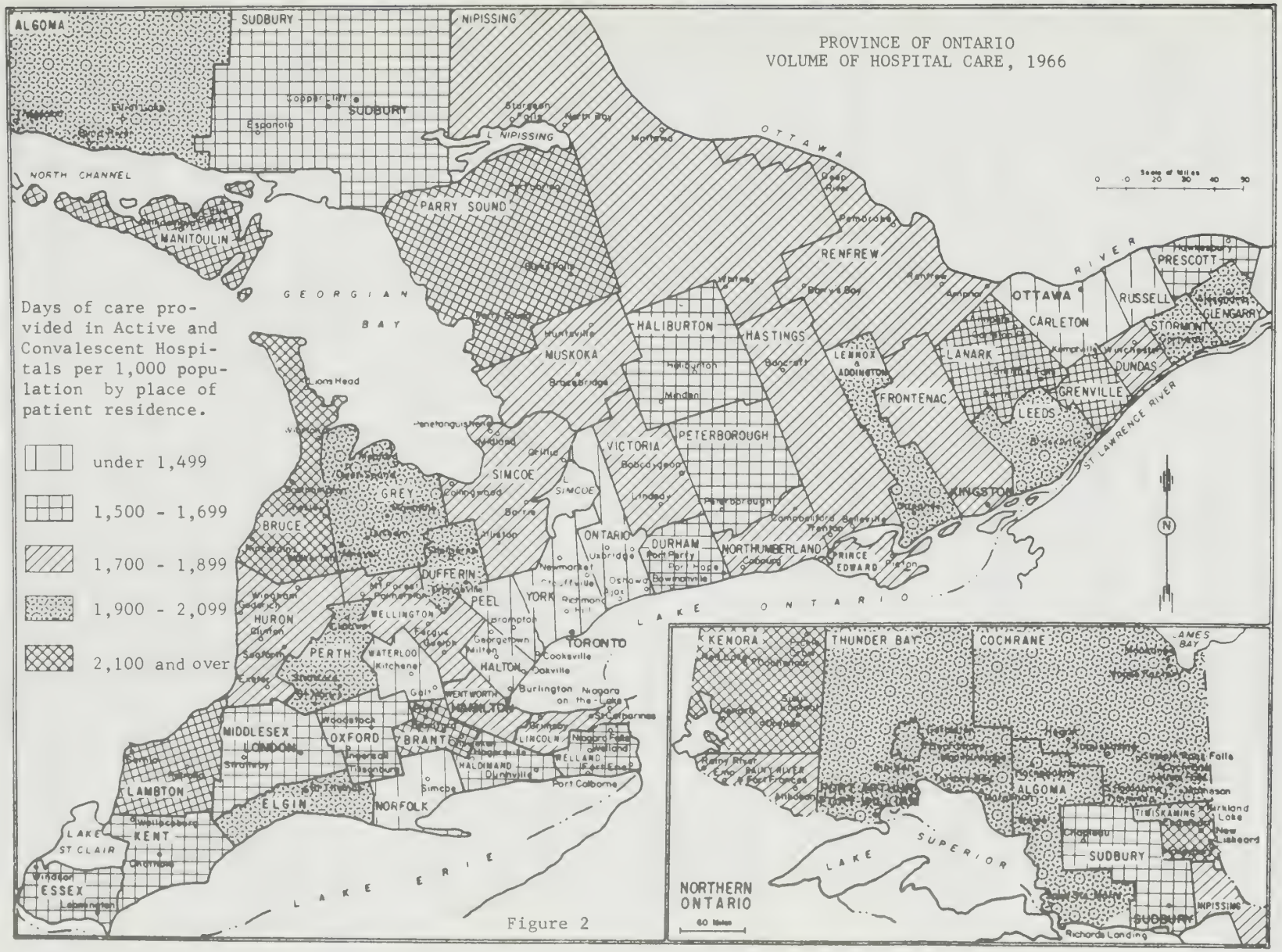

PROVINCE OF ONTARIO
VOLUME OF HOSPITAL CARE, 1966
Days of care provided in Active and Convalescent Hospitals per 1,000 population by place of patient residence.
under 1,499
1,500 - 1,699
1,700 - 1,899
1,900 - 2,099
2,100 and over
ALGOMA
SUDBURY
NIPISSING
PARRY SOUND
MANITOULIN
NORTH CHANNEL
GEORGIAN BAY
MUSKOKA
HALIBURTON
HASTINGS
RENFREW
OTTAWA
PRESCOTT
RUSSELL
CARLETON
GLENGARRY
STORMONT
DUNDAS
LANARK
LENNOX ADDINGTON
FRONTENAC
GRENVILLE
LEEDS
KINGSTON
PETERBOROUGH
VICTORIA
SIMCOE
GREY
BRUCE
DUFFERIN
PEEL
YORK
ONTARIO
DURHAM
NORTHUMBERLAND
PRINCE EDWARD
HURON
WELLINGTON
PERTH
WATERLOO
HALTON
TORONTO
WENTWORTH
HAMILTON
MIDDLESEX
OXFORD
BRANT
LINCOLN
WELLAND
HALDIMAND
LAMBTON
ELGIN
NORFOLK
KENT
ESSEX
LAKE ST CLAIR
LAKE ERIE
LAKE ONTARIO
ST LAWRENCE RIVER
OTTAWA RIVER
NORTHERN ONTARIO
KENORA
THUNDER BAY
COCHRANE
ALGOMA
SUDBURY
TIMISKAMING
LAKE SUPERIOR
JAMES BAY

Figure 2

purposes, but cases and days per 1,000 population provide a different facet of the overall picture.

Insurance Coverage
The Ontario Hospital Insurance Plan

18. Care of most patients in active treatment hospital beds in the province is paid for under the Ontario Hospital Insurance Plan. The benefits available under that Plan should, therefore, be explored, since this might affect use.

19. When the Plan commenced operation in 1959, all in-patient and only emergency out-patient services were covered. No time limit was placed on length of stay in hospital; the criterion used was medical necessity for hospital care in active, convalescent or chronic facilities. Since 1962, out-patient benefits have been gradually broadened, so that now they include, in addition to emergency services, hospital visits to conclude treatment of a fracture originally treated on an in-patient basis or as an emergency on an out-patient basis; radiotherapy for benign and malignant conditions; and hospital visits when medically necessary for surgical procedures and the treatment of medical conditions. The extension of out-patient coverage has eliminated the gap between the benefits under the Hospital Insurance Plan and the Medical Services Insurance Plan. This means that pre-surgical laboratory and X-ray work can be done on an out-patient basis at no cost to the insured at the time of service if he is insured under both provincial plans, hospital and medical, or if he has another type of medical insurance with the same type of coverage as OMSIP.

20. Physiotherapy, occupational therapy, speech therapy, audiological assessment, psychological assessment and medical social work are also insured services on an out-patient basis. In addition, insured persons are entitled to receive these services as out-patients in rehabilitation and crippled children's centres. Private physiotherapy facilities have also been approved to provide office treatment, or treatment in the patient's home.

21. Not covered under the Hospital Insurance Plan is care in domiciliary institutions—i.e., nursing homes and homes for the aged.

Other Insurance Plans

22. Reduction in in-patient utilization has been achieved in pre-payment plans which emphasize comprehensive ambulatory care, in which services are rendered by physicians in organized medical groups, where the philosophy relates to health maintenance, not to the episodic treatment of particular conditions, and where there are incentives to care for the patient outside the hospital.

23. Among the best known of these is the Kaiser Foundation Health Plan on the west coast of the United States. Information on the Oregon Region will serve as an example. Hospital in-patient utilization experience of Plan members for the past twenty years is shown in Table 6. While factors such as age, employment status, and socio-economic condition of the membership may make superficial comparison with the general population inconclusive, the decrease in rates is most significant.

Relationship to other Health Care Facilities

24. Effective relationships among hospitals and other facilities and programmes are essential if continuity of patient care is to be achieved. Too often, now, co-ordination of operational activities is lacking, making it difficult for the patient to know where he should seek care, and impeding movement of the patient, as his needs change, to the facility where his specific requirements can be met by the most appropriate programme.

25. Active treatment facilities are affected by co-ordination with all other levels. Lack of co-ordination with programmes for ambulatory patients means the admission of patients to active treatment beds who could be cared for as well or better by programmes and facilities designed for the mobile patient; lack of co-ordination with convalescent, chronic, and domiciliary facilities or with home care and other community programmes, means a back-up of these patients into accommodation designed for the acutely ill. This problem is further complicated by fragmentation of responsibility for overall control of these facilities and programmes among the Department of Health, the Hospital Services Commission, and the Department of Social and Family Services, and lack of an overall method for financing the individual's care.

26. Effective relationship between smaller hospitals and teaching

centres also is essential. It is through this relationship that advances in medical science can be brought to those living in the more remote areas of the province. Such formal relationships do not now exist to any great degree in Ontario.

Responsibilities for Planning, Administration and Operation

27. The Ontario Hospital Services Commission has the legislative responsibility to "ensure the development throughout Ontario of a balanced and integrated system of hospitals and related health facilities." The local hospital board is responsible for hospital operations, however, and local initiative is still much involved in planning for new or enlarged public hospitals, or in planning for changes in operating programmes.

28. Inherent in this local initiative is the element of competition among hospitals in the same or neighbouring towns for prestige, for professional staff, and for available local funds for construction purposes. This competition may be encouraged by local medical men, especially in understaffed areas, who depend on the hospital to provide a base of operations. Local politicians may also become involved in attempting to push schemes forward.

29. The Hospital Services Commission has made a beginning in encouraging responsible community participation in the area-wide planning process, by setting up advisory district planning councils in areas which express interest. Through this mechanism, the community can come to know what the needs are and what alternatives might be available to meet these needs, and can become involved in the setting of priorities.

30. While the initiation of building projects is a local responsibility (encouraged, perhaps, by the Commission), it is the Commission which reviews these proposals, and has the authority of approval or rejection. In its review related to active treatment hospitals, the Commission uses the overall standard of 5 beds per 1,000 population served. This is based on 1,550 days of care per 1,000 population. The standard is intended to provide beds for acute care and for an unspecified amount of convalescent care. It is scaled to take into account the age structure of the population served in the particular area under consideration, and to make allowance for the patterns of referral from small community hospital centres with fewer than 100 beds, to larger district centres with 100 to 500 treatment beds, and to regional centres

in which medical schools are located. This overall standard of 5 beds per 1,000 population is used as a guide, but not as an upper limit as far as approvals are concerned. Flexibility is stressed in dealing with individual situations.

31. Approvals-in-principle are given to meet the projected needs five to ten years in the future, to make allowance for the time between project initiation and completion. After approval-in-principle has been granted, detailed reviews of the building plans at various stages in their development, are made by Commission staff, in an attempt to ensure the achievement of construction at a reasonable cost, and with regard to cost of operations. This is considered essential since costs of less than three years operation are now equivalent to the original cost of construction. Provincial grants cover two-thirds of construction costs, with the remaining one-third being the responsibility of the local board; in the case of teaching hospitals, grants cover 100 per cent of the costs.* Part IV of this Appendix provides more detail concerning the planning process.

32. Although the local hospital board is directly responsible for hospital operations, the Commission is also concerned since it, in effect, meets operating costs. Individual hospital budgets are examined in detail by the Commission, and payment made of approved budgeted operating costs, subject to year end audit and adjustment.

Hospital Operating Costs

33. Cost of care in public general hospitals accounts for 30 to 40 per cent of total health costs, and the most expensive component of that care relates to the acutely ill.

34. Rising costs are a source of growing concern. Table 7 indicates the increases which have occurred over the past twenty years, in Ontario, and in the United States.

35. Before the inception of the Hospital Insurance Plan, costs per patient day and per capita in Ontario hospitals were below those in the United States. Since the Plan came into being, Ontario costs per day are still lower, but per capita costs are higher. This relationship is a reflection of the longer length of stay in Ontario hospitals.

* Grants include Federal contribution.

36. Costs by province and by U.S. region are also of interest (Table 8 and 9); most notable are the considerable variations which exist from area to area.

37. While some cost relationships mentioned here are based on patient days, this is not considered a desirable measurement. Indeed, overstressing this index in the budget review mechanism might contribute to increased lengths of stay in hospital, in order to reduce per diem costs. If length of stay were shortened, thereby making the care provided more concentrated, costs per day could be expected to rise. Cost per admission is perhaps more meaningful; in Ontario this rose from $176.00 in 1957 to $495.00 in 1967. Most relevant would be a standard which would take cognizance not only of in-patient care, but also of care provided to patients not admitted as in-patients; that is, a standard related to total patient care.

38. Much of the rise in cost is attributable to increase in costs of personnel. In 1957, salaries and wages accounted for 65 per cent of the gross costs, and in 1967, this figure was 67 per cent. Since Ontario salaries and wages are still below those paid in the United States, it may be expected that these costs will continue to rise. Another factor contributing to costs, and worthy of special note, is the operation of hospital diagnostic and treatment services on a 40 hour week while the hotel-type support services result in an overhead cost 24 hours a day, seven days a week.

39. Costs may also be looked at in relation to type of facility (active, convalescent and chronic) and to broad function (health services and "hotel" services). While these figures cannot be obtained with precision, the generalizations shown in Table 10 do provide some indication of the situation on a per diem basis.

40. Operating costs are not available for active treatment beds only; figures for public general hospitals include those for the associated convalescent and chronic units. Costs related to the hotel function include dietary, laundry and linen, housekeeping, and operation and maintenance. This function may, therefore, be considerably understated, since no attempt has been made to include any portion of the nursing or administrative costs related to the hotel function. The figures in parentheses are the most significant component of each function.

41. Despite the limitations of these figures, it is obvious that total

costs, and costs for both the health services and the "hotel" functions, are lower in convalescent and chronic facilities than in active treatment facilities. They also suggest a need for more analyses related to alternative methods for the performance of these two categories of function.

Comments

42. The present pattern of care for the actuely ill is characterized by gaps in some areas, overlaps in others, unnecessary and wasteful duplication of expensive and rarely used equipment, and a maldistribution of facilities and programmes. Too few alternatives to costly in-patient hospital care are available; some of the hospitals in operation in the province have too few beds to provide care effectively, and too much separation exists between facilities and programmes for the acute, convalescent, and chronic phases of illness, for physical and mental illness, and for other special categories of patient care. These problems have led to inefficient use of manpower and physical resources, and to rising costs.

43. Much of this is an inheritance from the past, and in the last ten years, since the inauguration of the Hospital Insurance Plan, steps have been taken to overcome some of these difficulties. More still needs to be done. The problems stem largely from the lack of an overall system for the delivery of health care in the context of which the need for various types of physical facilities can be considered. They also stem, in considerable degree, from the lack of co-ordination among the organizations involved in planning and operating all types of personal health care services at the provincial level, and at the local level.

44. In order to facilitate co-operation and co-ordination, a reorganization is necessary, among the provincial departments and agencies involved in the provision or financing of personal health care, either directly, or in the administration of legislation and regulations.

45. There is too little opportunity for responsible local participation in the process of planning for new facilities and programmes, and too few opportunities exist for local initiative and for making adaptations to local conditions within provincial standards and guidelines related to the overall health services system. In addition, too little co-ordination of operational activities and

insufficient co-operation among individual health care institutions exist at the local level.

46. To overcome these problems, regional and district health councils need to be established, with an appropriate restructuring of responsibilities and delegation of authority from the Provincial Government for planning and operational co-ordination. Within this organizational structure, encouragement should be given to the planning of facilities and programmes which would be of optimum size, in relation to effective use of health resources (personnel, available funds, etc.) while still related, on an area-wide basis, to the needs of population served. Facility expansion, renovation, change of function, and closure, should be related to this goal. In addition, within the regional structure, the health sciences centres of universities should be strongly encouraged and provided with the resources to take a more active role in total professional continuing education, in closing the gap which now exists between advances in medical science and their application to patient care, and in catalysing operational evaluation of systems of health care which may influence patterns of education for the health professions.

47. The present methods and procedures involved in the process of planning for acute care facilities seem unnecessarily complicated, restrictive and time-consuming. To enable revision and simplification of these procedures, a re-evaluation of the whole process is necessary with respect to incentives for responsible and innovative planning and to simplify techniques of monitoring and approval. This should involve studies such as the roles which should be performed at the institutional, community, district, regional, and provincial levels, the inter-relationships which should exist among these levels, and the policies which should form the basis for planning and approval of new facilities and programmes.

48. In planning new or renovated active treatment facilities, considerations relating to operational efficiency must assume top financial priority since total operating costs may be expected to exceed capital outlay within three years. Worthy of special mention is the need to involve in the planning process at the local level, the health and administrative personnel who will have continuing responsibility for the operation of the facility after its completion.

49. The indications are that too many beds are classified officially as active treatment, and that the number of admissions and days of care per 1,000 population are unnecessarily high. Too many beds are occupied by those who do not need the level of institutional bed care best provided by an active treatment facility or who might be more appropriately cared for as ambulatory patients or at home. The provision of too many levels of institutional care in an undifferentiated way makes more difficult the assignment of personnel and equipment appropriate to the patient's actual needs, and precludes the special design of facilities to meet these needs.

50. Studies should be undertaken of institutionalized and non-institutionalized populations to determine what current needs are for various levels of care, types of programmes, and facilities, taking cognizance of the reasons causing different patterns of admissions and days of care per 1,000 population throughout the province. In addition, sufficient time should be spent in evaluating the alternative possible solutions to assure that the new policies introduced will result in the provision of care in the most effective manner. These studies should be co-ordinated with the development of new standards on which the planning of hospital facilities could be based, and of the methods by which these standards are applied, with a view to establishing planning ratios more precisely related to levels of care appropriate to patient needs.

51. If the impression that a significant portion of active treatment beds are occupied by other categories of patients is validated by the studies suggested above, then it would seem that where practicable, conversion, renovation, and new construction should be directed to the provision of other levels of care and facilities, for either ambulatory or bed ridden patients, which are less expensive to operate and more appropriate to patient needs. These should be in place of, not in addition to, present active facilities.

52. Consideration should also be given to the establishment of group practice clinics and community health centres as a substitute for small hospitals, to provide a base of operations for health professionals. In such instances, existing inefficient and ineffective small hospitals should be phased out and replaced with these facilities for ambulatory patients.

53. Rising costs of hospital operation are of concern. Too little information is available about the means by which hospitals could reduce the volume of in-patient care provided, improve operating efficiency and reduce the cost per unit of service rendered. Hospital operations need to be analysed in terms of the functions carried on, and their costs. Studies need to be made of increasing the amount of service to patients who are ambulatory rather than in bed, of the establishment of self care units or hostels, and of the alternative methods of providing the supporting services which are normally accommodated in an active treatment hospital, and which are not required at the bedside (e.g. joint servicing or contracting for services). Extension of the work week for health services and reduction of the hotel component of hospital costs need to be explored to reduce the unit cost of health care delivered to the population through the active treatment hospital. The Provincial Government should support experimental approaches related to these and other concepts which could have implications for planning, design, and construction of facilities in the next decade.

54. The present system of operational reimbursement does not provide the necessary incentives to encourage the most efficient hospital management. In addition, the practice of reducing the budget to a cost per patient per day basis lends encouragement to lengthening patient stay to keep beds filled and percentage occupancy high. The budgetary policy should be such that it allows for incentives for good administration by allowing for less rigidity with respect to surpluses. While the determination of how such incentives can be applied has no simple answer, studies should be undertaken to accomplish this.

55. The present hospital and medical care insurance mechanisms do not discourage high utilization of hospitals. The public, the physician and the hospital administrator all put stress on in-patient care. Too little emphasis is placed on prevention of serious illness and on encouraging alternative programmes to in-patient care. A start has been made through extended out-patient coverage and home care programmes, but the insurance mechanisms should be modified to act as stronger inducements to use the most economic means of providing care appropriate to the actual needs of the patient.

56. Too little comparative operational and medical information for use in planning and managing health facilities and services is

routinely available to those involved in the provision of these services. Steps need to be taken to overcome this shortcoming and to increase local awareness. The need to include more effective facilities for ambulatory, emergency and psychiatric services are dealt with in other sections of the report.

TABLE 1. Distribution of Active Treatment Hospitals and Beds by Ownership, December 31, 1968

Ownership Category	Hospitals		Rated Beds	
	No.	%	No.	%
Public general hospitals	190	83.0	37,191	95.4
Red Cross hospitals	13	5.7	179	.5
Private contract hospitals	17	7.3	667	1.7
Federal hospitals including Nursing Stations	9	4.0	952	2.4
TOTAL	229	100.0	38,989	100.0

Source: Ontario Hospital Services Commission

TABLE 2. Trends in Active Treatment Hospital Utilization					
Year	Beds per 1,000 pop.	% Beds occupied	Cases per 1,000 pop.	Days per 1,000 pop.	Average Stay
1947	3.6	89.7	105	1,117	10.6
1957	4.5	85.1	139	1,363	9.8
1962	5.2	83.9	148	1,503	10.2
1967	5.2	82.1	149	1,572	10.5
Source: Ontario Hospital Services Commission Annual Reports 1957, 1962, 1967					

TABLE 3. Canada: Public and Private General Hospital Care by Province, 1966*

Province	Rates per 1,000 Total Population			Average Days Per Admission
	Rated Beds	Admissions	Days of Care	
Canada	6.4	156	1,888	12.1
Newfoundland	6.3	132	1,479	11.2
P.E.I.	6.6	166	1,687	10.1
Nova Scotia	5.8	151	1,611	10.7
New Brunswick	5.9	169	1,792	10.6
Quebec	6.1	135	1,767	13.1
Ontario	6.5	151	2,000	13.2
Manitoba	6.3	173	1,872	10.9
Saskatchewan	7.6	219	2,274	10.4
Alberta	8.1	195	2,163	11.1
British Columbia	5.6	169	1,732	10.3

* Public and private active, convalescent, chronic and allied special hospitals are included. Excluded are Federal hospitals, and those for tuberculous and mental patients.

Source: Compiled from Dominion Bureau of Statistics, *Hospital Statistics*, Volume 1, 1966.

TABLE 4. United States: Public and Proprietary General Hospital* Care by Region, 1966

Region	Rates per 1,000 Civilian Pop.			Average Days per Admission
	Rated Beds	Admissions	Days of Care	
United States	4.3	140	1,215	8.7
New England	5.1	142	1,450	10.2
Middle Atlantic	4.8	130	1,418	10.9
South Atlantic	3.8	135	1,088	8.1
East North Central	4.3	141	1,258	9.0
East South Central	3.8	144	1,039	7.2
West North Central	5.2	159	1,395	8.8
West South Central	3.9	146	994	6.8
Mountain	4.1	149	1,068	7.2
Pacific	4.0	134	1,071	8.0

* Public and proprietary short and long term hospitals are included. Excluded are Federal hospitals, and those for tuberculous or mental patients.

Source: Reed, Louis L., and Carr, Willine, "Utilization and Cost of Hospital Care: Canada and the United States," *U.S. Social Security Bulletin,* November, 1968, p. 14.

TABLE 5. Cases and Days per 1,000 Population, by Selected Diagnostic Category, for Three Counties in Southern Ontario,* 1966

Diagnostic Category	County	Cases per 1,000 pop.	Days per 1,000 pop.	Average Stay
Diseases of the Circulatory System	A	13	193	14.6
	B	20	337	16.9
	C	16	258	16.5
Diseases of the Respiratory System	A	20	115	5.9
	B	30	195	6.5
	C	31	187	6.0
Diseases of the Digestive System	A	20	174	8.8
	B	24	253	10.5
	C	24	230	9.8
All diagnostic categories	A	139	1,374	10.0
	B	181	1,997	11.0
	C	173	1,774	10.3

* Rates based on county of patient residence; included are adults and children separated from active treatment and convalescent hospitals, no matter where these were located.

Source: Ontario Hospital Services Commission.

TABLE 6. Kaiser Foundation Health Plan, Hospital Utilization Experience, Oregon Region

Year	Average Length of Stay	Admissions per 1,000 pop.	Patient Days per 1,000 pop.	Surgical Procedures per 1,000 pop.
1947	7.6	N/A	N/A	N/A
1949	5.5	146	798	106
1957	6.0	128	767	65
1962	6.3	109	687	63
1966	5.4	93	498	52

Source: Saward, Ernest W. et al, "Documentation of Twenty Years of Operation and Growth of a Prepaid Group Practice Plan," *Medical Care*, Vol. 6, No. 3 (May-June) 1968.

TABLE 7. Costs of Operation, Public General Hospitals

Year	Cost per Patient Day		Cost per Capita	
	Ontario*	U.S.A.+	Ontario*	U.S.A.+
1948	7.78	11.58	10.08	12.50
1957	15.68	23.94	24.68	26.25
1962	26.24	34.47	46.24	39.09
1967	40.86	45.46†	76.30	55.23†

Ontario: Public general active, convalescent and chronic hospitals.
U.S.A. : Public and proprietary short and long term hospitals.

Source : * Compiled from figures in Ontario Department of Health and Ontario Hospital Services Commission Annual Reports.
+ Reed, Louis L. and Carr, Willine, p. 19.
† 1966

TABLE 8. Canada: Cost of public general hospital* care, by province, 1966

Province	Total Cost (in thousands)	Per patient day	Per capita
Canada	$1,281,045	$35.74	$64.00
Newfoundland	24,078	32.71	48.84
P.E.I.	4,892	26.61	44.88
Nova Scotia	41,449	34.04	54.83
New Brunswick	35,741	32.39	57.93
Quebec	401,817	43.94	69.51
Ontario	457,037	34.88	65.66
Manitoba	55,888	31.29	58.04
Saskatchewan	62,678	28.60	65.63
Alberta	94,399	29.86	64.52
British Columbia	101,432	31.76	54.13
Yukon	174	52.68	12.43
Northwest Territories	487	33.76	16.79

* Public active, convalescent, chronic and allied special hospitals. Excluded are private hospitals, Federal hospitals, and those for tuberculous and mental patients.

Source: Reed, Louis L., and Carr, Willine, page 20.

TABLE 9. United States: Cost of non-Federal general hospital* care, by region, 1966

Region	Total Cost (in thousands)	Per patient day	Per Capita
United States	$10,703,091	$45.46	$55.23
New England	796,590	49.63	71.49
Middle Atlantic	2,429,082	46.86	66.38
South Atlantic	1,271,014	40.97	44.66
East North Central	2,200,779	45.00	57.00
East South Central	511,615	38.89	40.07
West North Central	887,491	39.88	56.14
West South Central	790,913	43.34	42.78
Mountain	373,158	44.43	49.02
Pacific	1,442,449	55.64	59.37

* Public and proprietary short and long term hospitals are included. Excluded are Federal hospitals, and those for tuberculous and mental patients.

Source: Reed, Louis L., and Carr, Willine, page 20.

TABLE 10. Per Diem Hospital Operating Costs, by Type of Hospital and by Function, 1967

Type of Facility	HEALTH SERVICES		HOTEL SERVICES		Total Both Functions
	(Nursing)	Total	(Dietary)	Total	
Public general hospitals*	($17.05)	$34.00	($4.24)	$9.92	$43.92
Convalescent hospitals	($ 9.18)	$15.44	($3.19)	$6.48	$21.92
Chronic hospitals	($ 8.65)	$12.99	($2.94)	$6.19	$19.18
All Types	($15.98)	$31.41	($4.08)	$9.45	$40.86

* Convalescent and chronic units included.

Source: Ontario Hospital Services Commission Annual Report, 1967.

TABLE 11. Primary Diagnoses of Adults and Children Separated from Active and Convalescent Hospitals, 1966 for Three Selected Counties and the Province of Ontario[1]

ISC Chapter Number and Broad Diagnostic Category[2]	ISC Number[2]	Separations per 1,000 Population[3]				Days of Care per 1,000 Population[4]				Average Length of Stay			
		County A	County B	County C	Prov.	County A	County B	County C	Prov.	County A	County B	County C	Prov.
I Infective and Parasitic Diseases	001-138	1.5	2.7	2.0	1.5	13.5	22.4	20.0	17.0	9.0	8.4	9.9	11.6
II Neoplasms	140-239	8.9	11.7	9.2	9.2	157.1	206.4	154.6	155.6	17.6	17.7	16.7	16.9
III Allergic, Endocrine, System, Metabolic and Nutritional Diseases	240-289	3.2	5.2	5.9	4.0	42.2	72.8	72.0	58.8	13.2	14.0	12.2	14.6
IV Diseases of the Blood and Blood-Forming Organs	290-299	0.8	1.5	0.9	0.9	6.8	23.9	11.9	12.1	8.2	15.5	13.4	14.3
V Mental, Psychoneurotic and Personality Disorders	300-326	4.5	6.0	4.6	4.5	63.1	86.7	82.6	79.2	14.0	14.4	18.1	17.8
VI Diseases of the Nervous System and Sense Organs	330-398	6.5	9.0	8.7	7.7	92.3	119.5	114.8	111.6	14.2	13.3	13.2	14.5
VII Diseases of the Circulatory System	400-468	13.2	19.9	15.6	13.4	193.2	336.6	257.6	236.4	14.6	16.9	16.5	17.6
VIII Diseases of the Respiratory System	470-527	19.7	29.9	31.0	24.6	115.1	195.2	187.2	141.6	5.9	6.5	6.0	5.8
IX Diseases of the Digestive System	530-587	19.8	24.1	23.5	19.7	173.8	252.8	229.6	206.6	8.8	10.5	9.8	10.5
X Diseases of the Genito-urinary System	590-637	13.1	17.0	15.7	13.7	116.6	144.8	127.5	119.5	8.9	8.5	8.1	8.7

TABLE 11 continued

ISC Chapter Number and Broad Diagnostic Category[2]	ISC Number[2]	Separations per 1,000 Population[3]				Days of Care per 1,000 Population[4]				Average Length of Stay			
		County A	County B	County C	Prov.	County A	County B	County C	Prov.	County A	County B	County C	Prov.
XI Deliveries and Complications of Pregnancy, Childbirth and the Puerperium	640-689	23.2	24.7	23.2	25.7	122.2	162.0	145.8	153.9	5.3	6.6	6.3	6.0
XII Diseases of the Skin and Cellular Tissue	690-716	1.5	2.9	2.8	2.5	12.0	32.1	32.0	23.9	7.7	11.2	11.3	9.6
XIII Diseases of the Bones and Organs of Movement	720-749	4.6	7.7	6.5	5.5	69.4	127.1	89.6	93.9	15.0	16.5	13.8	17.1
XIV Congenital Malformations	750-759	0.9	1.4	1.4	1.4	10.5	15.2	21.7	18.9	11.8	10.9	15.5	13.4
XV Certain Diseases of Early Infancy	760-776	0.3	0.4	0.6	0.3	2.9	4.4	5.9	4.4	9.2	11.1	10.8	13.2
XVI Symptoms. Senility and Ill-Defined Conditions	780-795	2.7	2.7	4.7	3.3	20.0	18.2	25.8	21.9	7.3	6.8	5.5	6.7
XVII Accidents, Poisoning and Violence (Nature of Injury)	N800-N999	13.8	13.9	16.0	13.5	151.6	171.5	181.9	153.2	11.0	12.4	11.4	11.4
Y Supplementary Classifications for Special Admissions, Livebirths and Stillbirths[5]	Y00-Y88	0.5	0.6	0.5	1.1	11.8	5.7	13.1	43.2	24.9	9.8	26.8	37.5
Total, all causes		**138.9**	**181.3**	**172.8**	**152.5**	**1.374.1**	**1,997.4**	**1,773,6**	**1.651.7**	**10.0**	**11.0**	**10.3**	**10.8**

Source: Admission-Discharge Forms processed between January 1, and December 31, 1966.

[1] These statistics include:
(a) All Ontario residents hospitalized in public and private hospitals in Ontario;
(b) Insured Ontario residents hospitalized in out-of-province hospitals;
(c) Out-of-province residents hospitalized in public and private hospitals in Ontario;
(d) Patients hospitalized in Federal hospitals for whom O.H.S.C. was responsible.

[2] International Statistical Classification of Diseases, Injuries and Causes of Death, 1955 Revision.

[3] Includes all patients who were discharged from or died in hospital.

[4] Includes days of care accrued to all patients who were discharged from or died in hospital.

[5] Adults and childen only are included.

SECTION 2

Special Purpose Hospitals

General

57. A number of special purpose hospitals exist in the Province, to provide care to patients with specific types of illnesses, or to specific age groups.

58. Predominant among these are hospitals which exist as separate entities and which care for the mentally ill and the retarded, and for convalescent or chronic patients who are physically ill. These are dealt with in other sections of this Appendix concerned with facilities providing these types of care. A number of special purpose active treatment hospitals also exist, for the treatment of specific diseases such as cancer, orthopaedic conditions, hernias, and for the treatment of children. These special purpose active treatment hospitals are included in the active treatment section with those providing services to a wider range of patients. Some special purpose hospitals have, in the past, pioneered in the development of new techniques. In some instances, the more intensive treatment and reduced length of stay have been given recognition by the Hospital Services Commission in a high per diem allowable cost.

59. This section is concerned with Sanatoria for Tuberculosis patients only.

Tuberculosis Sanatoria
Quantity and Distribution

60. Over the past number of years, a significant change has taken place in the use of sanatorium facilities. A decrease in tuberculosis morbidity and a shortened period of sanatorium treatment have meant that fewer in-patient beds are needed. Sanatoria facilities not required for tuberculous patients have been converted to accommodate other types of physically ill patients, or those who are mentally ill or retarded.

61. At the end of 1967, 12 sanatoria with 1,062 beds for tuberculosis were in operation in Ontario, in Brantford, Cornwall, Fort William, Hamilton, Kingston, Kitchener, London, Ottawa, St. Catharines, Sudbury, Weston, and Windsor. During the year, 63.2 per cent of the beds available were occupied. This is a significant decrease from the 15 sanatoria with 4,286 beds available in 1954. Since the end of 1967, the Cornwall and Brantford Sanatoria have also been closed, reducing the bed capacity to 967 in January, 1969.

Planning, Administrative and Operational Responsibilities

62. Sanatoria are administered by local boards, under *The Sanatoria for Consumptives Act* and Regulations. This Act is administered by the Department of Health. Construction and renovation grants are available from the Department, and costs of operation are met by the Department, based on the review and approval of an annual operating budget, subject to year end audit and review.

63. The Department acts in a consultant capacity in all phases of tuberculosis control, and assumes the role of providing overall guidance for the development of services for those with tuberculosis. It is the long-range goal of the Department to close sanatoria gradually, and to have patients with tuberculosis treated in special chest services units of general hospitals in medical teaching centres, with one chronic unit to accommodate long-term maximum benefit bacillary respiratory cases. It has been estimated that this goal can be achieved within ten years. The possible exceptions are Fort William and Sudbury, due to geographic location, and the Toronto Hospital, Weston, due to large population and the need for treatment facilities for maximum benefit cases.

64. It is also planned that the official local public health agency will assume responsibility for chest clinic operation, so that the activities of voluntary associations related to the treatment of tuberculosis can be phased out. The Department will finance chest clinic operation and be responsible for medical supervision, while the local agency will be responsible for the public health aspects such as follow-up.

Comments

65. The Sanatorium concept (and the development of chest clinics operated by Sanatoria and the Provincial Department of Health) has resulted in the separation of tuberculosis diagnosis and treatment from the mainstream of medicine in general practice and in hospitals. This separation will be diminished in future with the treatment of tuberculosis in general hospitals and through chest clinics more closely associated with the public health programme.

66. This example of Tuberculosis Sanatoria raises one question in connection with special purpose hospitals in general. Is it desirable, from the point of view of service, of teaching or of research, that special purpose hospitals exist as separate entities?

SECTION 3

Rehabilitation Services

General

67. The defined goal of rehabilitation services is to assist the handicapped to achieve or be restored to optimal function. In practice, however, there is strongest emphasis on physical medicine with little attention to the role of rehabilitation in respiratory, cardiac and other disorders, and very limited use of social, vocational and educational approaches to rehabilitation. Successful examples of the comprehensive approach may be found in the programmes of the Workmen's Compensation Board, Department of Veteran's Affairs and certain voluntary agencies. Furthermore, because rehabilitation is isolated or separated from other aspects of medical care, the active and rehabilitative phases of treatment tend to be separate or sequential rather than concurrent.

68. There are a multitude of independent groups offering general and specialized aspects of rehabilitation services. At provincial level, the Departments of Health, Social and Family Services, Education and University Affairs, and agencies such as the Hospital Services Commission, the Workmen's Compensation Board, and the Alcoholism and Drug Addiction Research Foundation, are all active in various aspects of the field. The Department of Veteran's Affairs and Armed Forces at Federal level and voluntary agencies, such as the Canadian National Institute for the Blind, (C.N.I.B.), the Canadian Arthritis and Rheumatism Society (C.A.R.S.), the Society for Crippled

Children, Paraplegic Association, Cystic Fibrosis Association, and others, are all involved in and dependent on rehabilitation services.

69. Special rehabilitation centres exist to deal with patients with severe or prolonged disabilities and geriatric patients who can be helped by activation or rehabilitation procedures. Specialty facilities restricted to specific disabilities are exemplified by Lyndhurst Lodge in Toronto for quadriplegics and paraplegics, centres for the deaf and blind, rheumatic diseases units operated by C.A.R.S., and the Workmen's Compensation Board Hospital and Treatment Centre. Facilities for children tend to be set apart from those for adults and include crippled children's and cerebral palsy centres. In addition to the health oriented programmes there are a few vocational rehabilitation centres and sheltered workshops operated by public and voluntary agencies.

70. As with other types of health facilities, there is a distinction between those dedicated to rehabilitation with physical emphasis and those with a mental emphasis. Facilities for the mentally ill, mentally retarded, epileptic, and drug and alcoholic habitués tend to be disability oriented and separate from other rehabilitation facilities.

71. The rehabilitation services considered in this section are primarily those which are health oriented—that is, those provided in hospitals, and in out-of-hospital rehabilitation centres. Care in these, for insured services, is provided under the Hospital Insurance Plan. Also considered briefly are private physiotherapy facilities, which are also covered under the Plan. Less attention is given here to services which are vocationally oriented, although this is not intended to suggest that they play an unimportant role.

Health Oriented Facilities
Type, Quantity, and Distribution

72. Physical medicine and rehabilitation departments exist in most general hospitals. In large general hospitals and particularly in teaching hospitals, they serve as centres for the delivery of physical therapy services to in-patients and out-patients and are under the direction of appropriately trained staff. In smaller general hospitals the service is variable and often consists of a trained physiotherapist and certain physical therapy equipment.

73. All general hospitals over 100 beds, the majority of those with 50 to 100 beds, and seven of the 51 general hospitals, including Red Cross, with fewer than 50 beds, contain physiotherapy departments. Occupational therapy is available much less extensively; some hospitals as large as 350 beds do not have this service, while only 11 hospitals of the total of 145 with fewer than 250 beds have an occupational therapist on staff. Most hospitals classed as convalescent or chronic, or designated to provide special rehabilitation services, have both types of therapy. Among the hospitals providing in-patient services are the specialty facilities restricted to specific disabilities or groups, such as Lyndhurst Lodge for quadriplegics and paraplegics, and the Ontario Crippled Children's Centre, both in Metropolitan Toronto.

74. Twenty out-of-hospital rehabilitation centres for ambulatory (including wheel chair) patients have been approved and listed in the Regulations under *The Hospital Services Commission Act.* These are located in the large centres throughout the province. Facilities for children are usually separate from those for adults, and include crippled children's and cerebral palsy centres.

75. In addition, 212 private physiotherapy facilities have been approved to provide office treatment, or treatment in the patient's own home, throughout the province.

Responsibilities for Planning and Operation and Present Planning Programmes
Hospital Facilities

76. The local hospital board operates the hospital facilities in which in-patient rehabilitation services are provided, and initiates planning proposals, but the Hospital Services Commission exercises considerable influence in both these areas, as is indicated elsewhere in this Appendix.

77. At present, the Commission is encouraging the development of a number of regional rehabilitation referral hospitals, or groups of hospitals, in regional centres throughout the province. These are to provide rehabilitation-in-depth services, on an in-patient and out-patient basis, to the seriously disabled individual with special physical, social, and/or psychological problems. These regional referral units, according to the Commission, must be the focal point of service, education and research in this field, and the base should be a hospital having full university affiliation. A close

physical relationship with an active treatment general hospital is favoured rather than a hospital for the chronically ill. High quality organization is considered essential, as is the development of a sensible admission-discharge policy, to ensure that the unit is not choked with inappropriate cases.

78. The regional referral unit is likely to handle two types of patient—special rehabilitation-in-depth, and general convalescent patients who have passed the acute stage of illness but who still need care in hospital. It is the special rehabilitation patients who, in the Commission's opinion, need the regional referral approach.

79. In planning for special rehabilitation facilities the Commission groups convalescent and rehabilitation needs together, and uses the standard of 0.25 beds per 1,000 population. This is applied to the entire regional population served by the city under consideration. This standard, and the method by which it is applied, is currently under review by the Commission; it is considered that convalescent and rehabilitation needs should be dealt with separately, that convalescent beds should perhaps not be restricted to regional and major district centres, and that the standard requires review in relation to that for active treatment beds.

80. The special rehabilitation services which are covered under the Hospital Insurance Plan are the same whether they are provided in a hospital setting, or in an out-of-hospital rehabilitation centre for adults or children. They include physiotherapy, occupational therapy, speech therapy, audiological assessment, psychological assessment, and medical social work.

Out-of-Hospital Rehabilitation Centres

81. Out-of-hospital rehabilitation centres for ambulatory (including wheel chair) patients are operated by voluntary or public agencies, and it is the Department of Health which reviews programmes and approves these programmes prior to the centres' being listed in the Regulations to *The Hospital Services Commission Act.* Not all types of service are available at each of the 20 centres listed.

82. Both programme and budget are reviewed on an annual basis by the Department, budgets are approved by the Commission, and payments made by the Commission for approved costs. Costs

which are not covered by the Hospital Insurance Plan are met by the operating agency through its own fund-raising mechanisms.

83. Provincial grants equalling two-thirds of construction costs are available, and the Department pays for equipment.

84. The Department is encouraging the development of a two-tiered system of rehabilitation centres for adults and children separately, throughout the province. This is based on the regional and district boundaries used by the Public Health Division. Where possible, existing operating centres will provide the basis on which to build. In a number of areas, local boards are currently constructing new facilities and extending programmes.

85. Regional centres are to be located in Windsor, London, Toronto, Hamilton, Kingston, Ottawa, and the Lakehead. District centres are to be more widely distributed and are intended to serve populations of some 200,000 people. The regional centres are to provide treatment services for their own areas plus diagnostic and assessment services for the two or three districts within the spheres of influence of each. Patients are to go to the regional centre for assessment, then back to the district centre for treatment. The regional services are to be more extensive and sophisticated than the district, and will include all the therapies and other services covered by the Hospital Insurance Plan; prosthetic and orthotic services will be available and medical consultant services such as neurology and orthopaedics. A close liaison is to be maintained with area vocational rehabilitation services.

86. In the future, the Department intends to have regional rehabilitation consultants (probably occupational therapists) in each regional centre, to assist in co-ordination and to provide consultant services. It also intends to have mobile teams of consultants, each consisting of an occupational therapist and a physiotherapist, to provide primary assessment services to these living in Northern Ontario.

Private Physiotherapy Facilities

87. Private physiotherapy facilities are approved to provide services, by an interdepartmental committee composed of representatives of the Department of Health and the Hospital Services Commission. Some are approved to provide office treatment

only, some to provide treatment only in the patient's home, and some to provide both.

Vocationally Oriented Services

88. In addition to the health oriented facilities are sheltered workshops. These are administered by local voluntary boards, and provide for work assessment, work adjustment and training, or are terminal workshops; not all services are provided by each.

89. Approximately 90 have been approved under *The Vocational Rehabilitation Services Act, 1966,* which is administered by the Vocational Rehabilitation Services Branch of the Department of Social and Family Services. Most sheltered workshops in the province are approved under this legislation, and a number of others are in the process of making application for approval. To be eligible, they have to be incorporated under Part III of the Corporations Act, and must have a suitable programme and supporting staff. This programme has to be approved by the Vocational Rehabilitation Services Branch before the centre can be listed as an approved workshop. Sheltered workshops may receive capital construction and equipment grants and operating subsidies, and the Department purchases assessment and training services from these centres.

90. The 90 approved workshops are scattered throughout the province. Of this total, 57 are affiliated with the Ontario Association for the Mentally Retarded, 12 with the Rehabilitation Foundation for the Disabled, 9 with the Canadian National Institute for the Blind, 3 with the Canadian Mental Health Association, and 9 with community organizations such as the Society for Crippled Civilians, or the Amity.

Comments

91. The field of rehabilitation services represents in microcosm the major problems which plague the system for the delivery of health services in general. First, there is lack of adherence to superficially defined goals; secondly, the shortage of services is compounded by ineffective use of specially trained professional personnel; and thirdly, there is no overall co-ordination of the needs and efforts of the various public and voluntary agencies concerned with these services. In addition, there is insufficient recognition of the greatly increased volume of rehabilitation

treatment which should be occurring out-of-hospital and the lesser degrees of incapacity or disability which might benefit from rehabilitation therapy.

92. There would appear to be a shortage of suitably trained rehabilitation personnel and this may be held responsible for limitation of the scope of programmes. However, to date it has not been possible to quantitate need in this area. Furthermore, there is little objective evidence of the effectiveness of many of our current practices in physical therapy.

93. In planning facilities for rehabilitation services, several problems must be overcome. First, a relatively small number of highly skilled personnel (e.g. physiatrists, physiotherapists, occupational therapists), acting in an interrelated fashion, must be made to go as far as possible in meeting a large demand. Therefore they should perform in a consulting fashion, not only within the public hospital system but also to voluntary agencies and special interest groups. Secondly, the isolation of rehabilitation therapists must be overcome so that treatment is not restricted to patients who are specifically handed over to a physical therapy group, and that the chance is not lost to influence the general approach of the practising profession through continuing education. Thirdly, continuity of rehabilitation services is required from the active, convalescent or chronic hospital to the ambulatory, home care, and sheltered employment situations. A relatively large proportion of patients are incompletely treated during their stay in active treatment hospitals but can be maintained with supportive care over an extended period out-of-hospital.

94. One other major problem needs to be overcome before rehabilitation services can be provided effectively. There must be better co-ordination and integration among the Departments and agencies of the Provincial Government, and among voluntary organizations which are active in various aspects of this field.

95. In general the location of rehabilitation services should be closely integrated with other aspects of the delivery of physical and mental health care services in the ambulatory and hospital setting. Separate facilities may only be justified as regional centres for children and adults and ideally these should be linked with general treatment facilities to avoid the disadvantages of isolation. The special regional centres should act as a base for

teams of personnel which could be mobile to provide specialized services to other hospitals in the region, to chronic illness centres, nursing homes, and homes for the aged. In addition, the regional centre could be a resource with which voluntary agencies could contract for services. The regional resource should be affiliated with a university medical or health sciences centre as a base for the educational programmes of the several health professions concerned. In addition, it must be hoped that this linkage would stimulate objective appraisal of current practices and lead to research, development and innovation.

SECTION 4

Convalescent Facilities

Definition

96. Convalescent facilities are designed, staffed and equipped to provide care for patients whose recovery has progressed to a stage where acute care is no longer required but whose condition still requires many of the special facilities available in a hospital– regular or periodic medical attention and re-assessment, skilled nursing care and special techniques. The care provided for longer term convalescent patients tends to overlap with the care provided for chronically ill patients in respect to the frequency of medical attention and re-assessment and the facility needs of these patients.

Quantity and Distribution

97. There are 8 facilities designated as convalescent hospitals and 6 designated convalescent units of general hospitals in the province, with a total rated bed capacity of 1,142. The actual number of patients in hospital who require convalescent care cannot be ascertained from records kept at present. Some indications, however, may be obtained from a recent study conducted by the O.H.S.C. on 7 active treatment hospitals in the downtown Toronto area. This study found in a one day survey that in the order of 700 out of a total of 4,574 patients in acute care facilities could have been receiving care in convalescent-rehabilitation facilities. While recognizing the limitations inherent in the study and the further limitations of applying these proportions to the province as a whole, it can be assumed that a

significant proportion of the 39,000 average daily population in hospitals are in the same category—say 3,900 if only 10 per cent is used as an average as opposed to the 14 per cent found in the study. It should be noted also, that Metro Toronto has a higher proportion of separate convalescent facilities than is general throughout the province which would indicate that the foregoing is a conservative estimate of the number of patients who might properly be placed in convalescent facilities but do not require the rehabilitation-in-depth services of a Regional Referral Unit. The present distribution of the designated facilities (8 hospitals—6 units) is 7 hospitals and 1 unit in the Metro Toronto area, 1 hospital in Fort William, and the remaining 5 units located in Hamilton, Kitchener, Port Arthur and Ottawa.

Cost Characteristics

98. Insufficient data are available on the costs of delivering convalescent care, nevertheless, some crude estimates and comparisons are possible. O.H.S.C. experiences indicate that these levels of care cost about one-half that of acute care. This is substantiated by a comparison of the average gross operating cost per diem for general hospitals, which is $43.92, with that of convalescent hospitals which is $21.92. Table 12 compares active treatment and convalescent hospitals of similar size, located in Toronto, and shows the same proportions of cost even though there are some limitations in making such direct comparisons.

Planning, Administrative and Operational Responsibility

99. As convalescent care is provided as a hospital service, the O.H.S.C. administers the regulations which govern the planning, administration and operations of the facilities where this category of care is provided.

Relationships with Other Health Services

100. The normal flow for the convalescent patient is from active treatment, through convalescence to discharge. During the process, it is important that he does not occupy an active treatment bed after he no longer requires this type of acute care. The development of the Home Care Programme has made it possible to continue care for the convalescing patient in his own home when his condition, home and family circumstances indicate that this method of care best suits his needs.

Comparison with other Jurisdictions

101. Certain other provinces are placing emphasis on the provision of convalescent facilities. In British Columbia, for example, there is current stress on the establishment of so-called "activation units" in hospitals, the term growing out of the concept of applying active rehabilitation techniques to promote the recovery of function and to minimize residual disabilities. The tentative goal is 0.5 beds per 1,000 population with a corresponding reduction in active bed ratios. Alberta has made long strides with a different approach but the same objective. A whole system of "auxiliary hospitals" for both convalescent patients and the chronically ill, again stressing rehabilitation, has been rapidly extended over the province in recent years.

Comments

102. Convalescent facilities, as such, particularly those in active treatment hospitals or in immediate association with such hospitals, have been developed to only a limited extent in Ontario. Short-term convalescence, typically up to 30 days, tends to take place in active treatment hospital beds, and this holds as well for many patients undergoing long-term convalescence.

103. Many convalescent patients may properly be in active treatment hospital beds for short-term care, pending the earliest possible discharge to their homes (with co-ordinated home care arranged in advance as indicated). On the other hand, care could often be more effective and less costly if suitable patients were transferred to a convalescent unit designed and staffed for the purpose, a unit offering a cheerful, non-hospital environment and ample rehabilitation facilities of appropriate sorts. Such a unit would clearly be more suitable than active treatment hospital beds for long-term convalescents. Since many of the special facilities of a hospital should be close at hand, and since skilled nursing care and regular or periodic medical attention and re-assessment are requirements for such patients, the convalescent facilities should as a general rule be part of the hospital complex rather than separated geographically from the hospital. Convalescent care institutions separate from active treatment hospitals appear to be practical only in metropolitan areas where there is a sufficient volume of patients of certain types (e.g., post-orthopaedic surgery) to attract staff interested in serving in such specialized institutions.

104. In overall hospital planning, beds for convalescence tend to be merged with active treatment beds within such ratios as 4.0 or 5.0 beds per 1,000. Separating off the beds for a high proportion of convalescent patients would not only make a lower and more visible ratio of active beds a reporting and planning tool, but it might well have the effect of bringing about a net reduction in bed requirements. The whole pace of scheduling services and discharging patients from active treatment beds might be speeded up when the more leisurely approach associated with the presence of many convalescing patients was eliminated or minimized. The goal should be to organize the delivery of care in such a way that the patient receives effective care appropriate to his needs, skilled manpower is properly employed, and costs are related to actual requirements.

105. Convalescent care lies in a sense between acute hospital care and follow-up care in the patient's home environment. If such care is to be used with maximum effectiveness and economy, there must be close liaison between the professional services in the active treatment hospital or acute service of the hospital complex and the professional services of the convalescent hospital or unit, with a medical social worker being a natural catalyst in the promotion of early planning for transfers of patients and discharges to the home or place of congregate living where the patients may reside. When the personal physician is not attending the patient in the hospital or the convalescent facility, he should be kept informed of the patient's progress and plans for discharge, including the chance to participate in arrangements for home care for the patient, as required. There is need as well for liaison between the convalescent facility and the regional rehabilitation-convalescent centre, for occasional transfers of patients to the centre will be indicated.

TABLE 12. Comparison of Operating Costs between two similar sized Active Treatment and Convalescent Hospitals in Metro Toronto – 1967

Type	Name	Rated Beds	Gross Costs	Per diem Costs	Wages and Salaries
Active Treatment	Northwestern General	248	3,715,016	46.15	31.60
Convalescent	St. John's Convalescent	210	1,386,045	20.64	10.92

Source: Ontario Hospital Services Commission

SECTION 5

Chronic Facilities

Definition

106. Chronic facilities are designed, staffed and equipped for patients whose condition is assessed as being unstable, incurable or terminal but who require the special facilities available in a hospital—periodic medical attention and reassessment, skilled nursing care and special techniques with the goal of attaining the maximum degree of functioning that each patient's condition will allow. Care for the chronically ill tends to overlap with that provided for the longer term convalescent patient with respect to the frequency of medical attention and reassessment, and the facility needs of the patient.

Quantity and Distribution

107. There are 39 chronic hospitals, 77 chronic units in active treatment hospitals and 35 nursing homes which respectively have 3,672, 3,458, and 588 beds, making a total of 7,718 designated beds for the chronically ill in the health facility system of the province. Theoretically, by the ratio of 1 bed per 1,000 population, this number of beds should meet the requirement of the provincial population (7,306,000); however, indications are that many chronically ill patients are not being cared for in appropriate facilities. The O.H.S.C. study of downtown Toronto hospitals, previously referred to, despite its limitations, found 3 per cent (128 of 4,574) of the active treatment patient population could be

occupying chronic care facilities. This finding is more significant when it is noted that Metro Toronto has 2,116 rated beds available for the chronically ill and that this number is equal to or marginally exceeds requirements established with the adjusted ratio applied by the O.H.S.C. Information of this type is not available on a provincial basis, but if Metro Toronto is accepted as a better than average case, indications are that a significant number of chronically ill patients are occupying acute facilities throughout the province, without taking into account the number who are inappropriately placed in other, non-hospital facilities.

Cost Characteristics

108. There are insufficient data available on the costs of delivering chronic care; nevertheless, some crude estimates and comparisons are possible. O.H.S.C. experience indicates that chronic care costs from 1/3 to 1/2 that of active treatment. This is substantiated by their figures for 1967 which show the average gross operating cost per diem for general hospitals as $43.92 and that of chronic hospitals as $19.18. Table 13, using 1967 figures, compares an active treatment hospital and a chronic hospital of similar size, located in Toronto, and again illustrates the marked difference in costs though there are of course limitations in making such direct comparisons between institutions.

Planning, Administrative and Operational Responsibility

109. As care for the chronically ill is provided as a hospital service, the O.H.S.C. administers the regulations which govern the planning, administration, and operations of facilities where this type of care is provided.

Relationships with other Health Services

110. The chronically ill patient potentially requires access to health facilities providing different levels of care. Within the hospital system there is movement between acute and extended care facilities, while outside the hospital, contact is with Nursing Homes, Homes for the Aged, Rest Homes or the patient's own home under the Home Care Programme. It is important that the chronically ill patient be in the appropriate facility to receive the care required by his current health status.

Comparison with other Jurisdictions

111. Alberta's major effort to provide public facilities for the chronically ill has been noted. British Columbia is pushing "extended care" units in active treatment hospitals. The pattern in Manitoba is noteworthy in that ten special chronic care units are being added at key hospitals, with each having a close affiliation with one of the three rehabilitation centres in Winnipeg and Brandon. Regular consultative services are available from these centres and also direct help in meeting special manpower needs.

Comments

112. Substantial progress has been made in Ontario in providing special facilities for chronically ill patients who need periodic and sometimes regular medical attention, skilled nursing care, and many of the resources of the active treatment hospital. These are persons with significant medical problems and need for appropriate institutional care, a need which is recognized through coverage under the provincial hospital care insurance programme. Some of these patients need such care only until their condition has become stabilized of ameliorated, others may require such care the rest of their lives, and still others may require this kind of care only at intervals, being able to get along adequately at other times in domiciliary accommodation or in their own homes with suitable home care services.

113. A prevalent planning standard has called for the overall provision of 1 bed per 1,000 for the chronically ill, excluding mental illness. Since chronic illness is much more prevalent as age advances, although it involves persons of all ages, the ratio of chronic beds to the population aged 65 and over is also used for evaluation and planning purposes. While real progress has been made in achieving what may be a minimal goal, there are still districts of Ontario lacking the theoretical requirement in chronic beds, a lack only partially met by the temporary approval of certain nursing homes as chronic facilities by the O.H.S.C.

114. In discussing the problems of extended care with governmental experts familiar with all types of chronic and domiciliary facilities, the impression is gained that if chronically ill persons with medical problems were to be cared for in appropriate facilities and if there were to be a well-organized flow of patients between various

facilities on the basis of need, there might well be need for a greater supply of chronic beds than that called for under present planning. At the same time, of course, reductions in the supplies of other types of beds or reduced planning ratios would be possible, including those related to active treatment hospitals, nursing homes, and the bed care sections of homes for the aged and charitable institutions.

115. While a sound general objective is to help people stay out of institutions and to have them use the most economical level of institutional care when such is required, there is reason for careful study of the possible need to increase our resources for the care of the chronically ill. A lack of chronic beds appears to be one of the bottlenecks causing a back-up of patients under inappropriate care—whether it be in an active treatment hospital or a domiciliary facility. A review of policy in respect to this matter can be sound only if more facts are marshalled than are now available. A comprehensive survey is needed, based on a sample of the entire provincial population, in institutions of every variety and outside institutions, to determine the extent of need for all defined levels of health care.

116. Accepting the concept that the patient should at all times be receiving an appropriate level of care and that this implies the unimpeded flow of patients in appropriate directions, it is clear that the separate chronic care facility and units must have a whole range of liaison arrangements. Patients may be referred from acute care hospitals, from nursing homes, from homes for the aged, from rehabilitation centres, and from the community. Certain of these transfers may be for limited periods of time, with the patients reaching a point of improvement or stability, permitting their transfer to the setting from which they came or to their own homes. Arrangements for appropriate home care will often be a feature of discharge planning. It may be noted that a chronic care facility is one of the logical places for the formation and functioning of a health team prepared to serve community physicians and agencies as an assessment team to judge just what level of care should be provided for particular patients with chronic conditions and disabilities. Such teams typically include a public health nurse and social worker as well as one or more knowledgeable physicians.

TABLE 13. Comparison of operating costs between two similar sized Active Treatment and Chronic hospitals in Metro Toronto – 1967

Type	Name	Rated Beds	Gross Costs	Per Diem Costs	Wages and Salaries
Active Treatment	Northwestern General	248	3,715,016	46.15	31.60
Chronic	Our Lady of Mercy	300	1,725,838	15.86	11.90

Source: Ontario Hospital Services Commission

SECTION 6

Nursing Homes

General

117. Proprietary Nursing Homes; private, non-profit, Charitable Institutions; and public, non-profit, municipal Homes for the Aged and Rest Homes, comprise the domiciliary care facilities, within the Ontario concept of care. Persons requiring domiciliary care may be bed-ridden, semi-bed-ridden, or fully ambulatory. The types of service required by such persons may be outlined as follows:

(a) Maintenance, such as room, board, laundry, etc.;

(b) Supervision to ensure safety;

(c) Assistance with activities of daily living, e.g., dressing, eating, toilet, walking, getting in and out of bed, lifting in and out of bed, getting from bed to chair and turning in bed;

(d) Personal care involving, for example, the hair, skin, feet, care of the body and care of the bed;

(e) Basic nursing care and health supervision in the general surveillance and observation of the individual's health status provided by skilled nurses;

(f) Reactivation programmes;

(g) Drugs and routine medications.

Definition

118. A Nursing Home in Ontario is a proprietary institution operated for profit. It is a residential institution designed, staffed, equipped and operated for the purpose of providing domiciliary care including basic nursing care to persons of any age who require such care, subject to the admission policies of the operator of the Nursing Home.

Present Role

119. Nursing Homes came under Provincial Regulations through *The Nursing Homes Act* of 1966. The Department of Health is responsible for the licensing and inspection of these institutions and exercises this responsibility through Medical Officers of Health in each jurisdiction. The attainment of the intent of the Regulations (issued in 1967) has been slow, due mainly to the difficulties of bringing established Nursing Homes up to required physical and operating standards. As of 31st December, 1968, 3 Nursing Homes had been permanently licensed and 462 held provisional licenses.

120. The role of Nursing Homes, as facilities used in the delivery of domiciliary care, is difficult to define precisely. Being proprietary institutions, they are not required to integrate their planning for provision of facilities, admission policies, or fee structures with any comprehensive scheme to provide this type of care in a community or area. Nursing Homes may refuse admission of a patient requiring considerable nursing care, for example, or may discriminate against male patients as a class. This non-system of privately owned institutions exists side by side with the growing network of charitable and public institutions which offer the same general services. Since these latter institutions obtain financial support from public funds, they are subject to certain planning and operating constraints relating to community requirements. The nature of care provided in Nursing Homes and their clientele, largely persons over 65, often make their operations the meeting ground for services that are under the jurisdiction of the Departments of Health and Social and Family Services. This leads to complications in the co-ordination of services provided by separate Departments. The role of Nursing Homes is complicated further by the use of certain of them by the O.H.S.C. to provide care for the chronically ill as an insured service and by their major use in the Mental Health Program as Homes for Special Care.

Adequacy of Services Provided

121. The licensing process and inspections are based on standards designed to ensure that facilities, staff and programmes provide the proper care for residents of Nursing Homes. The almost universal provisional licensing which still prevails is an indication of the gap between objectives and accomplishments in respect to standards, although there is some overall progress. Several areas of concern have been noted by Medical Officers of Health. First, nursing home operators, particularly those in small homes, are not sufficiently trained in the requirements of their position to direct properly the functions of the homes to ensure the desired level of care. Second, the nursing staffs consist very largely of "practical nurses," a category which in Ontario does not correspond with the fully trained practical nurse recognized in certain other provinces and the U.S. Surveys indicate the proportion of full- and part-time nursing staff to be in the order of 22 per cent Registered Nurses (most of whom serve only a few hours each week), 62 per cent Practical Nurses and 16 per cent Registered Nursing Assistants and non-registered Graduate Nurses. The variety of personnel employed in Nursing Homes and the different types of training, together with a group of residents ranging from the well to the disabled and often the sick, make it difficult to assess the adequacy of the nursing staff in terms of numbers and qualifications. Third, concern has been expressed about the lack of regular medical supervision. Doctors are available "on call" more than on a regular visit basis. Fourth, there appears to be a general lack of appreciation of the need for activation programmes, e.g., physical and occupational therapy, and social and recreational activities for residents. Fifth, there is some lack of appreciation for the nutritional needs of residents and inadequacies in facilities for the preparation and serving of meals.

Quantity and Distribution

122. As of 31st December, 1968, there were 465 Nursing Homes providing 13,708 rated beds. Of this total, the O.H.S.C. had 558 beds designated and used for care of the chronically ill on a temporary basis and the Homes for Special Care Programme (Mental Health) had licensed 8,193 beds of which only 4,786 were occupied. This leaves a balance of 5,064 beds available to provide domiciliary care for residents from other sources.

123. Taking all Nursing Home beds into consideration, there are 1.84 beds per 1,000 population in the province. The ratio for residents

65 years of age and over is 22.7 beds per 1,000 population. The location of Nursing Home beds according to counties and districts shows a wide variation in the general ratio from 0 to a high of approximately 10 beds per 1,000 population.

Cost Characteristics

124. Private enterprise is responsible for almost 100 per cent of all Nursing Homes in the Province of Ontario, and as this represents over 13,000 beds, it can be seen how significant a role private effort has played in contributing to facilities for overall care in the province. By the same token, because Nursing Homes are proprietary institutions, it is difficult to determine meaningful cost characteristics.

125. Several major factors enter into cost considerations besides the need for profits. First, there is the matter of size of the institution. It has been shown that small Nursing Homes experience the most difficulty in meeting the standards set forth in regulations, mainly because of the costs involved. A minimum size of 30 beds for a Nursing Home is generally considered to be sound economically as well as functionally, and yet 198 or 43 per cent of a total of 465 licenced homes, providing 19 per cent of the total beds, fall into the category of 20 beds or under. Table 14 points out this problem of economically unsound institutions.

126. A second factor is the number of residents or patients in Nursing Homes who are supported by an agency of government. Analysis shows that 8,644 or 63 per cent of all Nursing Home beds are occupied by residents or patients who are agency-supported. A classification according to the agencies responsible is shown in Table 15.

127. A third major factor in cost considerations is that while agency-supported patients are paid for through the per diem rate of $9.50 on a province-wide basis, as of 1st January, 1969, the fees charged for accommodation to those who can and do pay for their own care differ partly by location and the type of facilities provided. The average daily cost of this latter type of care can range anywhere from $2.00 to $20.00. The highest costs tend to be associated with a now emerging group of superior homes, apparently aimed at those who can pay, sponsored increasingly by commerical chains of these institutions.

Relationships with other Health Services

128. The wide variety of health needs of residents and patients in Nursing Homes requires contact with a number of other health services. For those who become acutely or chronically ill requiring hospitalization, there must be readily available access to active or chronic hospital facilities, while those who require occasional medical attention or are ambulatory need access to a physician or dentist or other health services and facilities in the community. Transfers to public or charitable domiciliary care facilities are often required. It is important that there be sufficient facilities of all types in the community or region to ensure the free flow of patients between facilities so that they can be lodged in the facility appropriate to their current health status. One disadvantage for Nursing Home residents (unlike those in similar public institutions) is that if hospitalization is required, there is no guarantee that a bed will be available in that home at the time of discharge from hospital. This can have the effect of patient resistance to needed hospitalization.

129. For patients who must themselves pay for care in a Nursing Home, there is often an economic barrier impeding discharge from an active or chronic hospital facility, in which care is underwritten through the O.H.S.C, to the Nursing Home. This has the effect of damming back inappropriate patients in costly hospital facilities. Another economic problem, which may become more evident in the future, arises when a patient in one of the expensive Nursing Homes faces rising costs and dwindling resources (among other things raising the question whether such Homes should be required by law to provide minimal as well as luxury accommodation, as hospitals are required to do).

Comparison with other Jurisdictions

130. It is extremely difficult to make comparisons between the Nursing Home situation in Ontario and that in other provinces, largely because there is wide variation in terminology and there is also a general dissatisfaction with existing non-systems of facilities and groping toward bringing order and reason into this field. There is evidence of common recognition of the need for "intermediate care" institutions, to serve those who on the one hand do not require active or extended hospital care but who, on the other hand, have disabilities ruling out residence in a primarily ambu-

latory facility for elderly persons or others needing sheltered congregate living but little else.

131. In the western provinces there are indications of a trend toward meeting the need for intermediate care through publicly supported institutions. In Saskatchewan, for example, some of the new Nursing Homes are being established and operated by public union hospital boards. In Alberta, a major new public programme has emerged since 1964, the Alberta Nursing Home Plan. District boards, public in nature, are responsible for maintaining high standard Nursing Homes in their districts, with the help of substantial provincial subsidies. Private Nursing Homes are incorporated in this system, if they meet the standards, but since 1967 the establishment of any new private homes has been barred. As of 1968, some 2.7 beds per 1,000 were reported in Alberta Nursing Homes, with the aim being 3.0 per 1,000. Such figures must be viewed in the light of the policy that Senior Citizens' Lodges in Alberta are primarily for ambulatory, largely self-sufficient persons.

Comments

132. Setting any arbitrary ratio of Nursing Home beds to population, to serve as a goal, should be approached with great caution at this stage. There needs to be a sorting out of patients and residents in institutions of every type, to determine current and foreseeable needs in terms of appropriate levels of care for suitable persons. As stated previously, a thorough survey to determine such needs for facilities of different types should extend to the non-institutionalized population to uncover unmet needs for appropriate institutional care. Finally, such a study should explore vigorously the full potential of providing needed health services in the home or foster home, to avoid over-institutionalization.

133. There is evidence of the lack of overall planning of health services, with the needs for domiciliary care facilities being met unevenly and with too little reference to relationship to other services. The answer is in establishing broadly representative, regional and district health planning councils to be given maximum responsibilities and commensurate authority within provincial policy guidelines. Meanwhile, and on a continuing basis in any event, at the provincial level informed and somewhat haphazard co-ordination should be replaced by formal, consistently used co-ordinating mechanisms for the planning of health facilities, involving the O.H.S.C. and the Departments of Health and Social and Family Services.

134. The vast majority of Nursing Homes still have only provisional licences and there is indication that Regulations are not being enforced uniformly. The task of handling inspections and licensing on a uniform and effective basis could be made manageable by certain actions not heretofore taken, e.g., having training conferences of Medical Officers of Health, arranging formal orientation and training for Nursing Home Inspectors, and providing more consultative help from the central Department of Health or its Regional Offices.

135. Present Nursing Home Regulations should be amended to provide for control over the establishment and location of Nursing Homes and to require minimum standards governing the size and other basic criteria for the establishment of any new Home.

136. Nursing Homes often have such a mixture of different kinds of patients and residents that maintenance of good quality services is seriously impeded. Consideration should be given to subdivision of licensing of Nursing Homes with a particular licence for a Home designed to offer a particular level of service, and with a system of graded payment for care geared to levels of service.

137. Deficiencies in the operation of Nursing Homes are often a reflection of inadequacies in their administrators. Provincial Departments should institute or augment activities related to the training of administrative personnel of domiciliary institutions, working in collaboration where appropriate with the Associated Nursing Homes, Incorporated, of Ontario, and the Ontario Hospital Association. Consideration should be given to the registration of operators and administrators, with time permitted to obtain training to meet the required qualifications.

138. The financial barriers to the full mobility of patients have been noted. Such mobility is needed as between health care institutions of various types including the patients's home as a preferred facility for care. Study should be devoted to methods of financing care which distinguish between the health component of care and the ordinary costs of living in domiciliary and other long-term institutions and in private or foster homes, so that all health needs may be met in a balanced system of health facilities. Such a development should serve to strengthen such health components of care as skilled nursing and "activation" services.

TABLE 14. Size of Nursing Homes and Beds – December 31, 1968				
Size	Number of Homes	% of All Homes	Beds	% of Total Beds
20 Beds and Under	198	43%	2,669	19%
21 to 30 Beds	131	28%	3,223	24%
31 to 50 Beds	92	20%	3,317	24%
51 to 100 Beds	26	5%	1,610	12%
101 and over	18	4%	2,889	21%
TOTAL	465	100%	13,708	100%
Sources: Ontario Department of Health				

TABLE 15. Number of Patients in Nursing Homes in Ontario according to Agency responsible – December 31, 1968

Agency Responsible		Number of Residents/Patients		
Department of Health Homes for Special Care Programme		4,786	–	35%
Municipal Welfare		3,300	–	24%
Ontario Hospital Services Commission (35 approved homes)		558	–	4%
	TOTAL	8,644		
Total Number of Beds Occupied by Agency Residents/Patients		8,644	–	63%
Number of Beds Available for Private Residents/Patients		5,064	–	37%
	TOTAL BEDS	13,708		100%

Source: Ontario Department of Health

SECTION 7

Homes for the Aged, Rest Homes, and Charitable Institutions

General

139. Homes for the Aged, Rest Homes, and Charitable Institutions in Ontario are used to provide the same type of care as that described in Section 6—Nursing Homes, paragraph 117.

Homes for the Aged

140. In Ontario, these are facilities designed, staffed and equipped to provide domiciliary care for persons 60 years of age and over. There are two categories of Homes, publicly owned Municipal Homes operated under *The Homes for the Aged and Rest Homes Act* and privately owned, non-profit Homes operated under *The Charitable Institutions Act.* Both Acts are administered by the provincial Department of Social and Family Services.

Municipal Homes for the Aged

141. These provide three types of care:

(a) **Normal Care** – for persons who are up and around, but require some care and supervision;

(b) **Bed Care** – for persons who are confined to bed part-time or full-time, but who are not in need of hospital care;

(c) **Special Care** – for persons who are mentally confused or senile, but who are not mentally ill and do not require care in a mental hospital.

The admission policies of the Municipal Homes are set by regulations.

142. Newer Municipal Homes are constructed with separate sections designed, staffed, and equipped for each particular type of care. The present position in this respect is that 65 Homes have so-called "segregated" care as described, 3 have "semi-segregated" care with separate bed care units, and 5 have "congregate" care without differentiated facilities.

Rest Homes

143. A new category of public institution serving various age groups, Rest Homes are designed, staffed, and equipped to provide for the long-term care of patients seriously handicapped physically or mentally due to disease, accidents, birth defects, etc. Transfer of patients from Homes for the Aged to Rest Homes, as the latter are established, will reduce the proportions of bed-ridden patients in the Homes for the Aged and permit conversion of facilities to semi-bed and normal care. The admission policies of the Rest Homes are set by regulations.

Private, non-profit Homes

144. Operated as Charitable Institutions these homes are not required to provide all types of care as they are free to establish their own admission policies. At present, the percentage of bed care provided in these Homes is significantly lower than in Municipal Homes (12 per cent of the total occupants to 48 per cent of the total occupants, respectively), but numbers in bed care are increasing, mainly through those who were previously ambulatory residents of the Home.

Quantity and Distribution

145. Ontario has a total of 20,178 beds in Homes providing domiciliary care for the elderly, with 73 Municipal Homes providing 13,667 beds and 71 private, non-profit Homes providing 6,353 beds. In addition, the one Rest Home in operation provides 90 beds, and as a special programme, 26 Foster Homes are providing care for 62

persons on the same basis as Municipal Homes. Converted to indices of beds per 1,000 these figures represent 2.32 beds for the total population and 24.14 beds for the population age 60 and over. *The Homes for the Aged and Rest Homes Act* stipulates that each Municipality will maintain a Home or have access to one on a joint basis with one or more other jurisdictions. The majority of Homes are on a county, district, or city basis. Each Municipality may also establish Rest Homes. (One Rest Home is in operation as noted, two are said to be under construction, and others are planned for establishment when provincial funds become available for subsidies.) Charitable organizations have also established Homes in some of these jurisdictions, but the distribution and use of these Homes is less regulated even though some co-ordination is achieved through the financial support provided by the Province. The situation is that practically all jurisdictions have access to one or more facilities, but the majority of Homes have waiting lists for admission, particularly in the bed care sections.

Cost Characteristics

146. The cost of domiciliary care in Ontario is the responsibility of the individual, but important capital and operating subsidies are provided. The methods of applying this financial sharing differ between Municipal Homes for the Aged and the Charitable Institutions. For Municipal Homes, capital construction costs are shared on a 50-50 basis by the Province and one or more participating Municipalities. Operating costs for each facility are determined yearly and per diem rate is set for occupants based on the previous year's operating costs. Persons admitted pay for their care insofar as their means permit. The remaining balance of operating costs of the Home for the year is shared 70 per cent by the Province and 30 per cent by the Municipality. For Charitable Institutions, capital construction costs are in part met by grants from the Province of $5,000 per bed up to one-half the cost, whichever is the lesser. For operating costs the Province contributes to the cost of care of individual indigent persons up to 80 per cent of the net cost. Net cost is the difference between what the person pays and the actual cost in that institution up to a ceiling of $8.00 per day. Table 16 shows the average per diem net costs for Municipal Homes and Charitable Institutions for the years 1966 and 1967.

Planning, Administration, and Operation

147. The impetus to provide new facilities, additions, or renovations rests with the community for both the public Homes for the Aged and Rest Homes and the private Charitable Institutions. Approval by the Department of Social and Family Services is required in each case, using a ten-step procedure for the development and execution of plans on a joint basis. Approvals are based on the present and future needs of the community and are established by population surveys, estimates of potential users, and a review of other related community resources. Regulations under *The Home for the Aged and Rest Homes Act* and *The Charitable Institutions Act* stipulate the required standards and methods for administration and operation of the Homes, including provision for various elements of medical and nursing services. To ensure that standards are maintained, the Regulations of both Acts provide for inspections by provincial authorities.

Relationships with other Health Services

148. Because of the types of elderly and handicapped residents in Homes it is essential that there be not only basic nursing services and medical protection in the Homes but that there also be ready access to a number of health services in the community or district. Active or chronic hospital facilities are required by those who become acutely or chronically ill and there may be need at times for transfer for rehabilitation or mental care. Those who have minor illnesses need the services of a physician in the Home and the ambulatory may require diagnostic or other services available only outside the Home in the community or area. Dental services should be available both within and outside the Home. It is important that proper facilities and services be available to the residents when their health status changes so they may be lodged in a facility that is appropriate to their health need. Residents in Municipal Homes have their accommodation protected if they are expected to return to the Home after hospitalization.

Comparison with Other Jurisdictions

149. While statistical comparisons would be most difficult, because of differences in terminology and the evolving situation in all provinces, certain generalizations are possible. The existence of both public and private institutions for the elderly and disabled prevails across Canada. Since private institutions largely control

their own admission policies and thus fall short of meeting all needs on a uniform basis, there appears to be growing support for augmenting public facilities. There also is evidence generally of a sorting-out process gaining momentum, whereby largely self-sufficient persons are in congregate living by themselves, bed-ridden persons requiring basic nursing services and professional nursing supervision are in their own specially planned facilities, and so on. In various provinces there are "senior citizens' homes," "boarding homes," or "senior citizens' lodges," with the emphasis on providing a sheltered environment essentially for self-sufficient persons. Along with this sort of development one finds parallel systems of "nursing homes" as in Alberta and Saskatchewan, and "personal care homes" as in Manitoba, with the aim of serving in appropriate facilities those who require continuing, basic nursing services.

Comments

150. The Department of Social and Family Services is making commendable progress in setting standards, collaborating with local jurisdictions and charitable organizations in providing appropriate facilities for differing levels of domiciliary care, extending consultative services, and fostering educational programmes for administrators, physicians, and others serving the various Homes. The Department should receive the support required to strengthen and augment such activities.

151. The programme of developing public Rest Homes for incapacitated, bed-ridden, and severely handicapped persons should receive a high priority rating for provincial support (largely withheld at this time). This programme offers the opportunity to develop a system of high standard, local nursing homes complementary to the developments in the private sector. As it becomes established in more districts, moreover, it will serve to free up bed areas in Homes for the Aged, allowing the latter to meet more adequately the needs of largely self-sufficient persons who require domiciliary care. Such a network of Rest Homes will also break the logjam impeding the flow of patients to such suitable facilities from hospitals and from chronic hospitals and units. It holds promise of being one of the principal factors in reducing expensive active treatment hospital bed requirements throughout the province.

152. Co-ordination of planning of institutions with definite health service elements and implications should no longer be on an informal or haphazard basis. At the provincial level there should be

formal, consistently used planning co-ordination mechanisms involving the Department of Health and the O.H.S.C. along with the Department of Social and Family Services. As soon as practicable, health facilities planning should be centred in Regional and District Health Planning Councils, and these should be involved when Municipalities and the Department of Social and Family Services undertake to plan any facilities offering nursing care and combinations of medical, dental, physiotherapy, and other health services. Hopefully, planning bodies at all levels, faced with proposals to create institutions or enlarge existing ones, should satisfy themselves that the problem simply cannot be fully solved by using home care and other non-institutional services.

153. As brought out in the discussion of Nursing Homes, it should be possible to single out the health component of care in sheltered care facilities affording bed care and nursing and other health services, and to devise ways to cover the cost of this component of domiciliary care in an over-all provincial health insurance system. This would tend to break down financial barriers to care of the right person in the right place at all times.

TOTAL 16. Average Per Diem Net Costs
Municipal Homes and Charitable Institutions

FACILITY	1966	1967
Municipal Homes for the Aged	5.87	6.95
Charitable Institutions	4.98	5.73

NOTE: The lesser amount for charitable institutions is in part due to their ability to charge higher than cost rates for those residents who can afford better than standard accommodation.

SOURCES: Ontario Department of Social and Family Services

SECTION 8

Comprehensive Home Care Programme

General

154. Numbered paragraphs 154 through 163 which follow represent a description and analysis of the official Ontario programme of home care as currently promoted by the O.H.S.C.

Definition

155. The Comprehensive Home Care Programme in Ontario is a programme which arranges for and co-ordinates the use of a wide variety of services available in the community to meet the needs of persons in their own homes. The Comprehensive Home Care Programme comprises two separately organized and operated services as follows:

(a) **Home Care – (Treatment Services)** – This is a specialized, selective service providing the equivalent of hospital care in the patients's home. Patients are selected if treatment can be provided in their home, if the home is physically and psychologically suitable, if the required services are available in the community, and if treatment cannot be provided on an out-patient basis.

(b) **Home Care – (Services and Supervision)** – This is a service which makes arrangements for or delivers care to meet the needs of persons who are living in their own homes. The

service is broad in scope, providing continuing care and supervision for the proper maintenance of health and independence for individuals who cannot arrange or manage their own affairs.

Objectives

156. The objectives of the components of the Comprehensive Home Care Programme are as follows:

(a) **Treatment Services**

(1) To release hospital beds by early discharge of patients who can complete treatment programmes at home.

(2) To admit patients for treatment in lieu of admission to hospital.

(3) To arrange for, co-ordinate and control the use of services required for the treatment of the patient (under direction of the physician) in a manner that will make best use of all services and facilities.

(b) **Services and Supervision**

(1) To facilitate hospital bed clearance by assisting patients and families to work out plans for continued care to enable patients to leave hospital.

(2) To develop a satisfactory plan of care for each individual who requires such assistance, utilizing the available medical, social and welfare facilities and services in accordance with his needs.

(3) To make best use of all available facilities and services including hospitals, Homes for the Aged, nursing homes, official and voluntary community services as well as the full potential of the family and private resources.

(4) To provide advisory services, counselling and referral to help themselves to the greatest extent possible.

Present Position

157. Only the Treatment Services of the programme have been introduced in Ontario to date. Introduced with a pilot project in Toronto in 1958, operating programmes commenced in 1964 followed by the gradual introduction of additional programmes to a total of 13 in 1968, located as follows:

Metro Toronto	Kitchener/Waterloo
Ottawa	Lakehead
Guelph/Wellington/Dufferin	Peterborough
Hamilton	Burlington
London	Oshawa/Whitby
Windsor	Lincoln/St. Catharines
Brant	

158. An evaluation of available data for 13 programmes in 1968 gives approximate information as follows:

Average daily cost per patient	$8.55
Average total cost per patient	$256.37
Average number of days per patient	30.8
Total patient days – approximately	259,346
Total number of patients	8,366

Sources: Ontario Department of Health

Costs Characteristics for Treatment Services

159. The data base has not yet been sufficiently developed to obtain precise costs for individual programmes or provincial averages. The daily costs per patient range from a high of $12.08 in Burlington to a low of $4.66 at the Lakehead with the longest established programmes in Metro Toronto and Ottawa being $8.93 and $8.22 respectively. It should be noted that these figures do not include maintenance costs such as food, laundry, etc., but do include homemaker services when used. Conforming to the general policy in Ontario, Home Care (Treatment Services) as an alternative to care in a hospital qualifies for payment by the O.H.S.C. The costs for the services are shared on a 50/50 basis by the Department of Health and the O.H.S.C. The 1968/69 total budget was $5,650,000.

Planning, Administration and Operations

160. The following description refers to Treatment Services but the same principles are envisaged for the Services and Supervision programmes. The initial step in planning a Home Care Programme is assumption of responsibility by the community agencies or the medical profession. The provincial authority for assistance, guidance and approval of a programme is the Inter-departmental Committee for Home Care which is made up of representatives of the Department of Health and the O.H.S.C. The establishment of a Home Care Programme follows guidelines used by the Inter-departmental Committee and includes four major steps as follows:

(a) **The Initial Step** – initiated in the community by promoting interest and involvement of community agencies and the medical profession. A Study Committee is formed.

(b) **The Study Committee** – assesses community needs, taking into account the services of the medical profession, the hospital, the Health Department, the Welfare Department, the visiting nurses' association, municipal council, etc. Consults with the provincial authority to reach agreement on the feasibility of a Home Care Programme. Establishes a Steering Committee.

(c) **The Steering Committee** – establishes the objectives of the programme, evaluates community resources as to their potential to provide the services required by the programme, obtains agreement to provide support from all participating agencies, makes recommendations as to the agency which will administer the programme and obtains approval in principle from the Inter-departmental Committee.

(d) **Development of the Home Care Programme** – the agency designated to administer the programme proceeds with implementation planning, obtaining staff, preparation of financial estimates and the organization required to bring the programme into operation on a pre-determined date. The final step is accomplished with the close co-operation of the Inter-departmental Committee and their approval of certain aspects of the implementation process such as appointments of the Advisory Committee, The Home Care Staff and financial forecasts.

161. The local agency designated to administer the Treatment Services may be an agency such as the V.O.N., an agency created for the purpose, a hospital or a local health agency. The staff employed by the present Home Care Programme (Treatment Services) constitutes a separate division of the administering agency, operating with their own budget, bank account and accounting system, and office, telephone, etc. The staffs employed by the present programmes are administrative and provide no direct care of the patient other than the evaluation of his need and the co-ordination and control of the services required. All services such as visiting nursing, homemaker services, etc., are obtained from community resources.

162. While the same general arrangement is envisaged for the Services and Supervision programme, it is realized that the staff will likely need to provide more direct services than is the case for Treatment Services. This difference could require different staff arrangements and methods of operating. Prior to the establishment of Home Care (Services and Supervision) it is anticipated that representatives of the Department of Social and Family Services would join the Inter-departmental Committee on a formal basis and would provide guidance on development of these programmes.

Relationships with Other Health Services

163. The concept of a Comprehensive Home Care Programme is based on the premise that an appropriate type and amount of care can be delivered from community resources, whether the patient's need is for medical services, social services, or welfare services. It follows, therefore, that close co-operation between and among individuals, agencies and institutions, which together provide the full spectrum of care, is essential, if the patient is to receive appropriate care. In addition, sufficient facilities are required to provide for an easy flow between the patient's home and the appropriate facility if this becomes necessary.

Comparison With Other Jurisdictions

164. No attempt will be made to describe in detail the home care programmes in other provinces, but certain general comments may be helpful. Wide variations exist among the programmes in respect to sponsoring bodies, operating agencies, and scope of services. Since hospital-based programmes tend to concentrate on patients

discharged from the hospital to their homes, the view is widespread that home care programmes should be community-based and should be just as concerned about patients in their homes who need not go to hospital or for whom hospital care can be avoided by proper home care.

165. In certain jurisdictions, e.g., in British Columbia, it is felt strongly that the logical agency to administer the home care programme is the official health agency responsible for the health of all people in its area, i.e., the local Department of Health. The role of the public health nurse is evolving along lines of practical, high priority services to people, and her role can encompass the professional nursing component of home care, including the co-ordinating function. The local Department of Health can take on administrative responsibility for the programme in stride, without having to build a hierarchy of supervisors supervising more supervisors. The Department can draw on other community resources to round out a total programme.

166. In considering a programme with the potential of greatly reducing institutional care, we may well remind ourselves forcibly that in comparison with Great Britain, the Canadian people appear to be over-institutionalized. The Canadian Senate Committee on aging reported that in 1962-63, 77.2 per 1,000 or 7.7 per cent of the population aged sixty-five and over, were residing in some form of institution rather than in the community at large. The figure for Ontario was 84.7 beds per 1,000. In Great Britain, on the other hand, it has been estimated that in 1963 only 4.5 per cent of the population sixty-five years of age and over were in long and short stay institutions. At least one reason for this is the more readily available home care services in Great Britain giving the elderly an opportunity to remain in their homes much longer than in Canada.

Comments

167. While progress is being made in developing Ontario's Comprehensive Home Care Programme there appears to be considerable rigidity in the approach and there seems to be a lack of over-all clarification of objectives and policy. Much may be lost by failure to recognize the central role of local Departments of Health in developing needed services for individuals and families which have not been provided by other community agencies. A Department of Health may well decide to use V.O.N. nurses in carrying out its home care responsibilities, but many question the abdication of

over-all administrative responsibility to the V.O.N., a highly respected agency but one whose experience has been limited essentially to visiting nurse services.

168. It is difficult to comment on Ontario's Home Care (Services and Supervision) because it does not yet exist, nor do there appear to be models elsewhere in Canada. Certainly there is need for perplexed patients or their families to be able to get intelligent guidance as to needed care, the most appropriate place to be under care, and so on. Hopefully, the new "primary physician" will be schooled in being the sort of resource so frequently needed. A public health nurse seconded to serve with the family physician may be an excellent resource, as may be a medical social worker serving in a medical group practice. Among the most difficult questions are those facing the elderly infirm or the chronically ill, and elsewhere in this report, it is suggested that chronic care units have interdisciplinary professional patient assessment teams. The chief burden of this discussion is that the health aspects of "Services and Supervision" may well work best if woven into the fabric of on-going community health services.

SECTION 9

Community Health Care Facilities for Ambulatory Patients

169. The great majority of all personal health services rendered in the community are provided to essentially self-sufficient persons living independently in the community outside of health care institutions. This being the case, it becomes of economic as well as social importance to examine the physical facilities which constitute the settings in which the health professions provide the bulk of their services. Are these settings such as to foster personal, effective, efficient and economical care?

170. There are difficulties in the way of analyzing this important sector of the health care facilities system which exists in Ontario today. Most of the facilities have grown out of the personal preferences and planning of thousands of independent practitioners of the healing arts. Facts concerning physicians' and dentists' offices, as an example, are largely lacking. Unfortunately, facts are practically as sparse in respect to such more organized settings for health care as hospital emergency and out-patient departments, occupational health services, special purpose clinics, school health facilities, and facilities for public health services. Under these circumstances, a review of ambulatory care facilities must necessarily be incomplete and largely general in nature.

Facilities for Professional Health Personnel Practicing in the Community

171. A Canadian Medical Association Survey of the Medical Profession, according to a 1968 report, showed that of 8,222 respondent

physicians in Ontario, 5,180 or 63.4 per cent were in solo practice, 986 or 13 per cent were in two-doctor practices, and 2,056 or 25 per cent were practising in medical groups of three or more physicians. One cannot equate the number of solo doctors' offices with the number of solo practitioners, for example, since some of the latter may have offices in institutions and clinics of various sorts as well as having private offices. It *is* known that wide qualitative differences are found among practitioners' offices, as brought out in Dr. K. F. Clute's study, *The General Practitioner.* A considerable proportion of the private offices surveyed in Ontario revealed serious deficiencies from the point of view of modern medical care and efficiency. It seems likely that such deficiencies are less common in specialist practice, which is heavily urban in character and which in cities is frequently based in professional office buildings.

172. Data are not available on the number of physicians who now have their offices in teaching and other major hospitals on a "geographic full-time" basis, or those similarly housed on a part-time basis. Many others, of course, who frequently spend much of their time in clinical work in behalf of various segments of the community, are serving on a salaried or similar basis in service programmes maintained by federal departments, and in psychiatric care facilities, chronic disease hospitals, tuberculosis hospitals, and so on.

173. It has been reported that in 1967, there were 2,805 active dentists in Ontario, with 2,403 in full-time private practice, 155 in part-time practice, and 247 in salaried practice. The Royal Commission on Health Services noted in 1964 that "[dentistry] is perhaps the health profession least marked by salaried employment or the concentration of personnel in large groups. This manner of organizing dental service is accompanied by a generally inadequate level of dental health." Though forms of combined practice in Ontario have been cited, the vast majority of dentists are in solo practice, a pattern which makes difficult the full use of ancillary personnel with its attendant increase in productivity. Relatively few are in organized hospital, school, or other public health services, and a handful serve in the two Department of Health railway dental cars and three Red Cross mobile road dental coaches serving Northern Ontario.

174. According to the Royal Commission on Health Services, there were 533 optometrists in Ontario in 1960 (as compared with 115

ophthalmologists). Most optometrists are in private practice, largely in solo offices. Some 11 per cent of the optometrists in Canada in 1960 were employed in optical departments maintained by commercial corporations, a situation decried by the profession in Ontario as embarrassing and one which should be abolished by law. Both consumer-sponsored, group practice, comprehensive care plans in Ontario (in Sault Ste. Marie and St. Catharines) have optometrists serving in their modern group centres as integral elements in their medical group practice programmes.

175. Among other types of healing arts practitioners, two might be mentioned. Physiotherapists typically practise in a hospital or other institutional setting, but a considerable number in Ontario maintain private office and therapy facilities (a pattern which, though questionable in some respects, is fostered by payments for care made by the Ontario Hospital Services Commission). Podiatrists, relatively scarce in Canada compared with the U.S. and the U.K., generally practise in private offices, although their usefulness in hospital foot clinics, industrial health clinics, and medical group practices has been demonstrated elsewhere.

176. Medical group practices have been defined by the Canadian Medical Association as groups consisting of "at least three duly registered practitioners of medicine who practise together from a common office, sharing common records, pooling professional income, and distributing earnings on a pre-arranged basis." As mentioned previously, an estimated 25 per cent of practising physicians in Ontario are in group practice, a dramatic increase from the estimate of 10 per cent only a few years ago. A sample survey has shown that approximately 40 per cent of the medical groups in Ontario are general practitioner groups, 25 per cent are single specialty groups, and 35 per cent are multi-specialty groups (which often include general practitioners in the group). Regrettably, precise data are lacking concerning the number, size, composition, and use of professional and technical supporting staff for all medical groups in Ontario.

177. Typically medical group practices are sponsored by the participating physicians themselves. Among newer patterns, however, are family care groups of general physicians in teaching hospitals of the University of Toronto, the University of Western Ontario, and McMaster University. Various patterns of formal and informal group practice involving specialists are also appearing in teaching and other hospitals, often related to the increase in geographic

full-time practice. Mention has been made of the two consumer-sponsored groups in Ontario. Both the one sponsored by the Sault Ste. Marie and District Group Health Association and the one recently developed in association with the St. Catharines and District Community Group Health Foundation are multi-specialty groups with solid cores of key family physicians and with such well-developed supporting services as nursing, physiotherapy, pharmacy, x-ray, and laboratory services.

Hospital Facilities for Emergency and Out-Patient Care

178. As mentioned previously, factual information is unfortunately lacking concerning the precise provision made by hospitals for the handling of emergency cases and out-patients. However, such facts as are available will be presented briefly and inferences can be drawn from certain reported service and cost data. The O.H.S.C. recognizes two types of out-patient department:

(a) the organized out-patient department of the kind maintained by a teaching hospital, which consists essentially of a variable number of clinics, each of which provides a diagnostic or consulting service typically for the indigent population.

(b) the out-patient department of the ordinary public general hospital, which offers what is essentially an emergency service for the general population.

179. Information obtained through the O.H.S.C. shows that of 227 hospitals reporting for 1967, 187 provided some form of out-patient service. Of the 39 hospitals reporting no services, 2 were general hospitals with fewer than 100 beds, 13 were hospitals operated by the Red Cross, 8 were convalescent hospitals, 15 were hospitals for the chronically ill, and 1 was a hospital for patients with alcoholism or drug addiction.

180. The 187 hospitals reported for 1967 the following out-patient units of service, examinations, surgical operations and visits:

(a) Laboratory services 6,838,793 units

(b) Diagnostic radiological examinations* 1,403, 449 examinations

(c) Surgical services

Operating rooms	93,126 operations
Emergency units	422,092 operations

(d) Out-patient visits

Organized departments	558,299 visits
Other	3,100,397 visits

*Excluding convalescent and chronic hospitals and routine admission chest x-rays.

181. Statistical data are not complete for 1968. Table 17 shows a comparison of three hospitals of different sizes which provide out-patient services. Although the general trend is in the direction of rising volume of service year after year, certain of the increases shown in the table may also be related to the broadening of O.H.S.C. benefits on July 1, 1968.

182. As brought out elsewhere in this report, the out-patient service benefits offered by the O.H.S.C. have been broadened by stages since initiation of the programme in 1959. Such actions were taken in 1962, 1964, 1967 and 1968. Essentially, current benefits include diagnostic services within 24 hours after an accident (and follow-up care in fracture cases); radiotherapy, physiotherapy, occupational therapy and speech therapy; and the hospital component of all other out-patient services, including the use of operating room and anaesthetic facilities, surgical supplies, meals during treatment and drugs and biologicals used at the hospital.

183. The O.H.S.C. has reported the costs of providing various types of out-patient service, summarized in Table 18.

Facilities for Occupational Health Services

184. Occupational health services to maintain and improve the health of employees are considered today to constitute an important aspect of over-all community health programmes. Unfortunately, data are not available on the kinds of facilities in use in Ontario at this time, on the volume of services provided, or on gaps in services, but the following figures give certain useful information about the number of programmes known to be in operation, together with their over-all staffing:

(a) Sponsorship and Number of Occupational Health Services

Industry, Commerce, Government and Hospital	590
Universities and Community Colleges	26
TOTAL	616

(b) Employees by Category

(1) Physicians – full-time	50	
– part time	263	
TOTAL		313
(2) Registered Nurses – full time	895	
– part-time	46	
TOTAL		941
(3) Registered Nursing Assistants		27
(4) State Registered (U.K.) & Graduate (non-registered) Nurses		14
(5) Physiotherapists		2
(6) Dentists		1
(7) Psychologists (approximately)		4
(8) Other Auxiliary Personnel (not including first-aid workers)		45
Full-time and part-time GRAND TOTAL		1,347

School Health Facilities

185. Information is not available on the facilities for health services in schools throughout Ontario. In general, the facilities required are simply those nursing and first-aid facilities customary for occupational health services in progressive commercial establishments, supplemented by provision for vision and hearing screening tests. In some schools, space is allocated for dental examinations or topical fluoride applications.

Facilities for Public Health Services

186. Presumably because there is decentralization of public health services in Ontario, facts are unavailable centrally concerning the housing of local department of health staffs and the facilities available for carrying out programmed community health activities. The number of "free standing" community public health centres is relatively small. Most health departments are housed with other units of local government.

Comments

187. Facilities for ambulatory care cannot be considered apart from the services rendered in the facilities. If there are indications that services should be modified, or better distributed, or made available through improved patterns of organization, planning for facilities must be based on what services will be provided, by whom, where, and how.

188. The whole picture of ambulatory health care is in a state of flux, in a degree of disarray dictated by powerful current trends. The need is urgent to bring order and direction into this picture – to define objectives in the personal health care field, to plan how to attain these aims, and to move step by step toward their accomplishment.

189. A basic trend is seen in the on-rushing expansion of medical scientific knowledge and proliferation of sophisticated technical equipment for diagnosis and therapy. The continuing extension of professional and technical specialization is a concomitant of this trend, a phenomenon which makes medical care teamwork imperative for the rendering of scientific care. Rising costs of care are likewise related to these trends, forcing attention to be focused on practical and effective means of achieving economics in the health services.

190. The role of medicine has been changing markedly over recent decades. The main burden of medical practice is no longer treatment of the acute episode of infectious disease but coping with the rising tide of chronic degenerative disease, cancer, and mental and emotional disorder. The logical task of medicine has become primarily that of continuing health supervision – of prevention where possible, of health maintenance, early detection of chronic illness, alleviation of disability, rehabilitation, counselling and support.

191. Rising demands for health care and broad benefit health insurance constitute another trend, influenced by a multitude of factors such as better education, higher incomes, the flow of information about health through all media of communication, and experience with effective modern care and insurance protection.

192. Ironically, these rising demands from the public come at a time when physicians to serve people are in short supply, when the

number of family and personal physicians is dwindling, when medicine is compartmented in a score of specialties, when rural areas are rapidly losing doctors of any variety, and when physicians are leaving the hearts of our cities for the suburbs.

193. The ambulatory medical care complex is a maze at best and often fragmented and chaotic. People urgently need a point of access into the complex, preferably a physician who knows them and their ills, and who takes continuing responsibility for their welfare. And their physician needs to be able to mobilize all varieties of professional, technical, and institutional resources in the community or region in aid of his patients. For such purposes to be accomplished, there is need to achieve more order in today's health care complex – to provide understanding and competent physicians as specialists in family care, to co-ordinate the work of other specialists to supplement scarce professional skills through the use of collaborating and supporting health workers of many kinds, and in general to build toward a rational, co-ordinated system for the delivery of ambulatory and other forms of care.

194. The group practice of medicine is expanding rapidly in Ontario, as has been noted. Its advantages are such that continued spread of the pattern should be facilitated and promoted. All sorts of variations in the pattern are possible, depending on many circumstances but particularly on the needs of the rural or urban population to be served.

195. To the patient, group practice can offer a personal physician; the protection seven days a week which group organization makes possible; the convenience of obtaining various diagnostic, therapeutic, and consultation services under one roof; and the assurance that the participating doctors have passed the test of selection by other doctors who have confidence in them.

196. From the point of view of his professional life, group practice offers the physician the stimulus of constant contacts and easy consultation with his colleagues; the advantages of supporting professional, technical and clerical personnel far beyond what would be possible in solo practice; the chance to practise his profession without involvement in business details; and opportunities to attend scientific meetings and participate in refresher courses without loss of income. From the standpoint of his personal life, group practice can offer sensible periods on duty, vacations with pay, ample remuneration, and fringe benefits which

provide security against disability and the economic hazards of retirement and old age.

197. The group practice pattern has particular application in underserved urban neighbourhoods and in rural districts which do not attract and hold specialists who must make their way in competitive situations or which offer rather grim isolation to the solo practitioner.

198. It is not possible to provide functionally efficient hospitals in each community of the province. Smaller hospitals often designed to encourage the location of medical personnel in a community may be inefficient to operate and the quality of health services may be unsatisfactory because of lack of specialized professional technical personnel or equipment.

199. A special attempt should be made to establish a physical facilities base for ambulatory services in the community which offers many of the advantages of an active treatment hospital without its hotel component. These ambulatory service areas might be located to meet the need for accessibility of services to the public in less densely populated areas. By establishing groups of physicians, greater job satisfaction for the health professionals might be obtained by sharing of responsibilities and the increased volume of medical practice would justify supporting services not now generally available except in hospitals. The supporting services could include professional, technical and clerical personnel and laboratory and x-ray services. The physical facilities for ambulatory services should provide emergency care and maintain an active link by transportation and communication with a neighbourhood general hospital.

200. Preliminary studies of consumer-sponsored group practice in non-profit community clinics in Saskatchewan, where diagnostic and treatment services are set up independent of hospitals, indicate that hospital utilization and doctor generated cost per clinic patient were less than half the provincial average and that the number of patients seen per doctor was nearly double the provincial average. These results in 1966 and 1967 suggest that from the standpoints of cost, effective use of manpower, hospital utilization and quality and convenience of care offered, community clinics have much to offer (Reference: "Group Health and Welfare News," February, 1969, page 6, O.K. Hjertaas).

201. It would be a forward step, and one with implications of net

savings in health care costs, if the Department of Health were to make financial assistance available for non-hospital based facilities which provide emergency care, diagnostic and treatment services for groups of physicians and other health personnel whose practice efforts are directed at the delivery of health care in the community. The inclusion of social workers, public health nurses and certain services normally associated with public health clinics should also be encouraged. Special consideration in the granting of financial assistance should be given where there is a serious problem for the population in access to health services, either urban or rural, and where a method for the evaluation of the effectiveness of the programme can be instituted.

202. The pattern of medical group practice also has application, of course, to the community hospital situation, where good medical staff organization is often the forerunner of the organized medical group. Consideration of organized out-patient departments points up a particular problem. Such departments, which have evolved from the eighteenth century dispensaries for the sick poor, have largely outlived their usefulness even in the teaching centres. With universal coverage medical services insurance on the near horizon in Ontario, all patients will rapidly become private patients. As such, they should, if they wish, have personal or family physicians who care for them on a continuing basis and mobilize such consultant or other services as may be required. Under these circumstances, the multiple clinic O.P.D., with its heritage of hard benches, long waits and impersonality, would do well to transform itself into an appropriate form of medical group practice based in or adjacent to the hospital, with staffing by both "geographic full-time" physicians and part-time physicians.

203. It is a matter of common knowledge that with the difficulty in obtaining physicians' care today, especially at night and on week-ends, people are turning more and more to hospital emergency rooms. Regrettably, hospital emergency services have seldom been organized and staffed in such a way as to ensure prompt, humane care of high quality for acutely ill or injured patients. Today, the care of medical emergencies is further compromised by the rising tide of patients with non-urgent complaints who now flood hospital emergency rooms seeking primary medical care. There is clearly a need to introduce measures such as triage with appropriate action or referral, back-up staffing by specialists of several varieties, and improved ambulance services including two-way communication between ambulance and hospital. It

would be desirable to integrate emergency service staffing not only with a hospital's house staff but with a hospital-based group practice which would assume responsibility for proper handling or referral of non-urgent cases such as triage, as well as true emergency cases. Ambulance and emergency services should be planned and organized on an over-all regional and district basis, and emergency departments should be expanded or otherwise revised as required to meet today's needs.

204. The emphasis in school health services, another form of ambulatory care, has changed markedly in recent years. Such screening techniques as those for vision and hearing defects are still provided for, but once children enter school after a hopefully thorough pre-school health examination, the emphasis is on detection and follow-up of children with problems, with the teacher and public health nurse playing vital roles, rather than on the former periodic medical examinations. The facilities required are seldom more than an office for the visiting nurse and first-aid and screening equipment. Facilities for preventive dental services are sometimes provided, and policy may call for more routine provision of such facilities in the future.

205. Certain universities, colleges, and private schools find it appropriate to maintain well-staffed and equipped infirmaries for both ambulatory and bed care for students not having access to their homes and home community resources, at times of minor illness.

206. Certain large industries maintain adequate facilities and staff to carry out current occupational health practices. There are gaps in such services, however, some of which – involving small plants – could be filled through the co-operative sharing of the time of nursing and medical personnel and the provision of minimal facilities or use of a shared mobile unit.

207. Many local departments of public health offer a range of educational and preventive services to mothers, babies and children, and the community at large. It is a cliché to talk of getting the health department out of the courthouse basement, but the fact is that the community's basic programme of prevention and health promotion seldom finds recognition in a well-planned, attractive community health centre. Such centres are needed for many reasons, including enforcement of the point that public health services are for everyone and not just for the poor. Community health services can be strengthened, moreover, when

combined centres furnish facilities for key voluntary health agencies as well as the official agency. In certain rural or problem communities, offices could be provided for medical practitioners, facilitating useful collaboration between public health and clinical personnel in meeting community needs.

TABLE 17. Comparison of Hospitals of different size providing Out-patient Service

Hospital	Service	1967	1968
Port Hope & District (73 Beds)	Laboratory	6,012	9,407
	Radiology	4,519	6,132
	Surgical	695	805
	OPD (organized)	—	—
	OPD (other)	3,103	6,208
Women's College Hospital (280 Beds)	Laboratory	216,276	313,002
	Radiology	7,559	8,902
	Surgical	928	1,269
	OPD (organized)	3,962	5,310
	OPD (other)	13,836	16,543
Ottawa Civic Hospital (1,076 beds)	Laboratory	296,239	348,317
	Radiology	42,065	43,959
	Surgical	6,936	8,691
	OPD (organized)	6,503	8,332
	OPD (other)	64,129	70,245

Source: Ontario Hospital Services Commission

TOTAL 18. Cost of Out-Patient Service, 1966 and 1967

Services	1967	1966	% Increase or Decrease
Emergency	$5,466,679	$5,635,267	(3.0)
Follow-up & other	1,979,423	1,619,403	22.2
Sub-total	$7,446,102	$7,254,670	2.6
Therapy services	1,473,227	1,045,484	40.9
Private physiotherapy	2,499,034	1,493,665	67.3
Rehabilitation Services	1,356,397	515,167	163.3
TOTAL	$12,774,760	$10,308,986	23.9

Source: Ontario Hospital Services Commission

Part II
MENTAL HEALTH FACILITIES

SECTION 10

Introduction

1. The majority of mental health facilities in Ontario are planned, developed and administered by the Mental Health Division of the Department of Health. The Division is divided into four branches: Psychiatric Services, Mental Retardation Services, Professional Services and Hospital Management Services. Psychiatric Services operates a mental hospital system of 16 hospitals with about 14,000 beds; the branch for the Mentally Retarded is responsible for nine facilities for the retarded, with about 7,500 beds; the Hospital Management Services Branch provides consultants in all aspects of hospital management and is a back-up service for both of the operating branches; Professional Services are consultant and advisory to the provincial institutions and to outside agencies.

2. A Children's Services Branch is being established to implement arrangements for children with mental and emotional disorders. There will be eight regional centres and this Branch will co-ordinate the work of the centres and of community programmes.

3. The basic concepts pertaining to the care and treatment of the mentally ill and the retarded have progressed through a series of changes during the past century. Throughout this province, as in most other jurisdictions, the changes which have taken place can be readily identified by the nature, location and the size of the facilities for the mentally ill. The older institutions, built prior to the turn of the century, are of the "asylum" type. They present certain architectural features which are now outmoded, tend to be

large institutions, which have been made larger over the years, and are in isolated locations.

4. Early in the century, the facilities for the mentally ill gradually began to take on more of the characteristics of a hospital. They continued to be large institutions, and at one time, there was a plan in this province to construct three institutions to serve the whole province, each to contain approximately 6,000 beds. One institution of this type was started, but the concept was abandoned with less than half of the total capacity being constructed.

5. Still more recently, there has been a trend to the establishment of small regional hospitals of approximately 300 beds. During the past 15 years, it has been the practice to provide additional facilities which are required for the treatment of mental illness through the establishment of psychiatric units in general hospitals.

6. Until very recently, little attention was given to the special needs in the care and treatment of the retarded in the design of facilities for this purpose. Here again, the institutions identified for the retarded, have tended to be large and placed in relatively isolated locations. Under the present plans to provide services for the retarded on the basis of identifiable programme units which relate to the levels of retardation, the Province is developing facilities which will support these particular needs.

7. As a result, we have a collection of landmarks of this evolutionary process as represented by institutions of varying size, many of which are poorly located in terms of population distribution. In order to try and maintain some balance in the patient load, it has been the practice to identify each of the provincial hospitals with specific counties. The catchment areas so defined tend to be large and do not always take into account distance and the traffic routes usually followed by the population in obtaining health and other services.

8. Through the development of psychiatric units in general hospitals, the distribution of services has been improved so that facilities are more readily available in relation to the population needs. Because of obvious gaps relating to population centres of considerable size, this has not been difficult.

SECTION 11

Quantity, Size, and Distribution of Facilities

9. The Mental Health Division has recently completed a "Master Plan" for mental health facilities, using as a basis four planning areas (eastern, central, southwestern, and northern) covering the entire province.

10. The attached diagram (Figure 3) indicates the pattern of existing mental health services in Ontario. In the First Line (Community) Services are (a) the group of basic services, which are not specialized, and (b) the specialized psychiatric services. (More detail on the institutions included in the latter category is shown in Tables 20-22) The patient may be identified in either of these two groups. The specialized psychiatric services are tied into a basic model of a service area population of 75,000, the availability of five essential services (in-patient, out-patient, day care, emergency, and consultative services to local agencies of any type) provided at a ratio of 0.4 beds per 1,000 population served.

11. In the Second Line (Regional) Services are psychiatric hospitals providing general adult long-term beds. At present, beds of this type exist in the ratio of 1.4 beds per 1,000 population. The planning programme for the future (1976) is based on 0.8 beds per 1,000 population. In this group, in addition, are the special units indicated on the diagram.

12. Also among the Second Line (Regional) Services are the eight Regional Centres for children and adolescents. These short-term

diagnostic and treatment centres provide services at the highest level and are intended to give back-up support to community programmes. (These are listed in Table 24 along with the institution with which each is associated physically.)

13. The last of the Second Line Services shows facilities for the retarded—the regional hospital schools and the specialized training facilities (Table 23). Some psychiatric hospitals also have units for the retarded. The standard used in planning for these facilities is 1.5 beds per 1,000.

14. In connection with needs for services, studies are now in progress, by the four planning areas into which the province has been divided by the Mental Health Division, to relate numbers of beds needed to beds available. The situation is being assessed in relation to short-term psychiatric beds, long-term psychiatric beds, and facilities for the retarded, using the standards indicated above applied to the population of the four planning areas.

15. It is anticipated that the only new facilities required for short term care will be the psychiatric units built to meet needs created by population increase. Phasing out of some of the older buildings in provincial institutions is desirable but obviously cannot take place on a wholesale basis.

16. Future needs may well be affected by the results of research in for example the treatment of schizophrenic disorders. A major breakthrough in the next 10-15 years could mean a dramatic reduction in the need for institutional facilities.

Mentally Retarded

17. The "master planning" for the facilities for the mentally retarded has recently been completed by the Mental Health Division. The standard in use is 1.5 beds per 1,000 population (including adults and children) per institutional service. Four new regional training facilities are being planned at Sudbury, Peterborough, Toronto, and in the Niagara peninsula. They are each to be 300-400 beds in size. At present, regional training facilities exist in Cedar Springs, Orillia, Palmerston and Smiths Falls. Even when the new facilities are completed, the number of beds will still be below the 1.5 beds per 1,000 population standard. In any case this standard is not one which has been newly developed and its validity is open to question. It may be that, in future, more services for the retarded

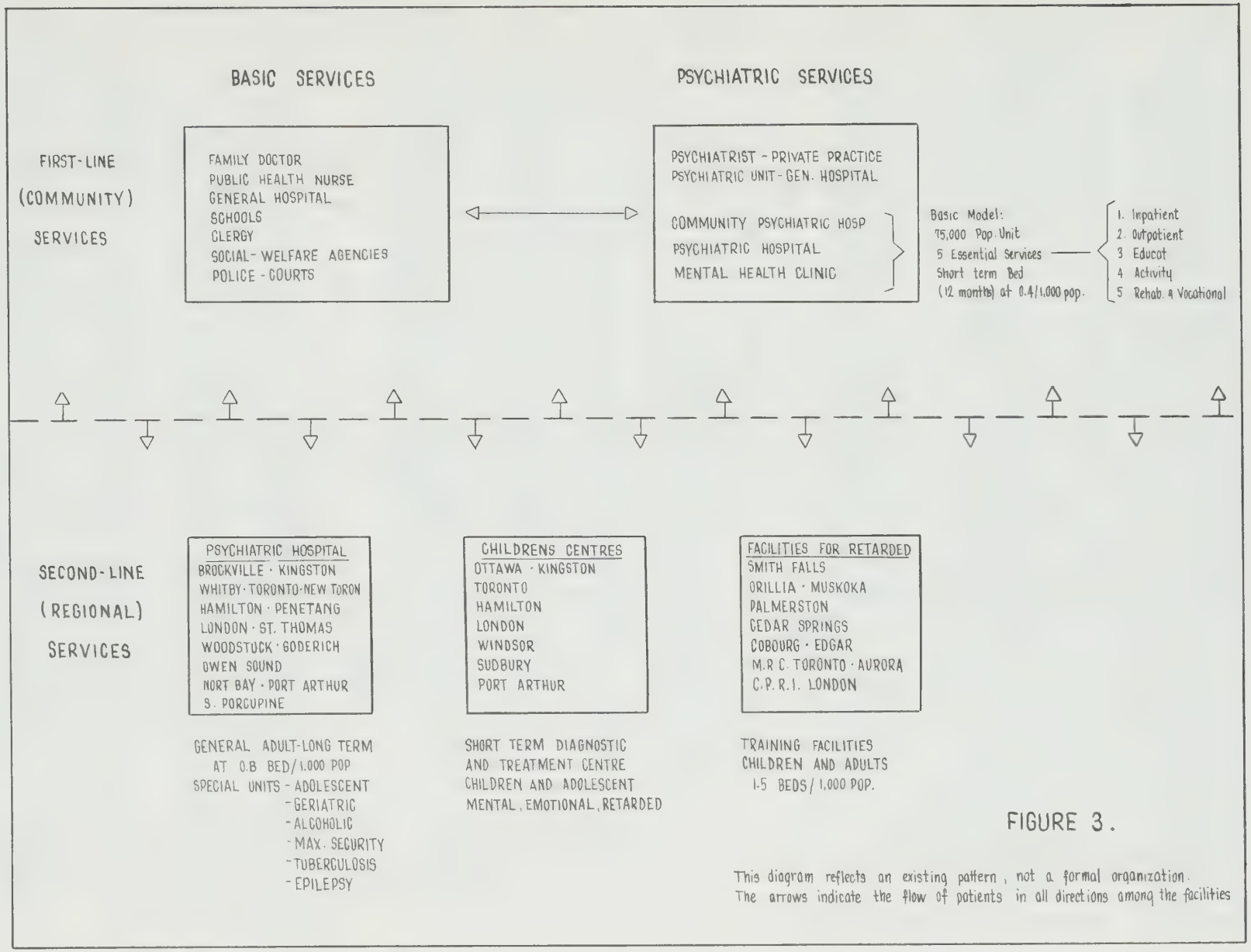


FIGURE 3.

This diagram reflects an existing pattern, not a formal organization. The arrows indicate the flow of patients in all directions among the facilities

will be available in the public school system. This is one of the recommendations of the Hall-Dennis report, and if implemented it would probably reduce the need for hospital-school facilities.

18. A new organizational pattern is being introduced into the facilities for the retarded. This is based on a four unit system, which is designed to take into account the medical needs and the degree of retardation of the individual. Not all facilities contain each of the four units. These units are:

    (1) medical-nursing: out-patient and in-patient diagnostic assessment services, and in-patient preventive and treatment services;

    (2) educational: the Department of Education employs the teachers and establishes the educational programmes which are operated in the health facilities;

    (3) activity: to increase self care and social skills;

    (4) rehabilitation and vocational: adult training programmes.

19. The retarded individual is placed in the appropriate unit so that he will live in a total, suitable environment. Staff training programmes have been established so that the unit system can be made to operate effectively.

20. Homes for Special Care provide for those who cannot benefit from further care in any of these four units. At present, an individual has to be in one of the mental institutions administered by the Department before he can be admitted to a home for special care.

21. In the Master Planning for the retarded, the ten facilities for the profoundly handicapped child, operated by private boards, have been included, (see Attachment 2). Certain problems are created when the government allows private enterprise to provide some health facilities, but these operate under *The Mental Health Act*, and construction and/or alteration have to be approved by the Minister.

Children's Services

22. A new Children's Services Branch is being established within the Mental Health Division in a commendable effort to provide

improved facilities and programmes for children with mental and emotional disorders. Eight regional centres for children have been established in Ottawa, Kingston, Toronto, Hamilton, London, Windsor, Sudbury, and Port Arthur. It is intended that they be tied in with the community programmes providing back-up services.

23. The Regional Centres all have special liaison officers attached to them, one from each of the five departments concerned with the programme (i.e. Health, Education, Social and Family Services, Reform Institutions, and the Attorney General). These liaison officers, and the head of the regional centre, form an expert technical committee, chaired by the Regional Medical Officer. The role of this committee is to provide guidance to community agencies developing programmes for children. It is not a planning group but it may offer advice.

24. The primary focus of the community programme is the psychiatric unit in the general hospital. These units are established in hospital centres which serve a population of 75,000 or more. While most general hospitals with psychiatric units have found it impracticable to admit children to the psychiatric unit, they are encouraged to provide psychiatric services within the paediatric departments. Children's hospitals also will be encouraged to make these services available. All psychiatric out-patient departments are to provide services for children as well as adults.

25. It is estimated that some 80 per cent of children's care could be provided at the Community Level of service, through small areas—perhaps 10 beds—in paediatric wards, and through out-patient departments and day care centres. At this level, the child would be assessed and a treatment programme would be worked out which would involve all community resources—medical, educational and social. The attempt would be to fit the programme to the child, not the child to the programme.

26. If an individual is identified in the community (for example, by a general practitioner, by a social agency, or a general hospital) as being retarded, he may go to one of the regional hospital schools. If he is emotionally disturbed, he may go to a facility for emotionally disturbed children.

27. If the child needed further assessment, he would go to a Regional Centre. If he required long-term residential care, he would go to another Second Line facility—the psychiatric hospital or the

facilities for the retarded. If he did not need long-term residential care, he would be returned to the community.

Sheltered Care

28. (a) **Homes for Special Care**—This programme which is administered by the Public Health Division was developed so that individuals no longer in need of care in a psychiatric hospital or in a facility for the retarded, but who do need some type of sheltered care, could be moved to more appropriate accommodation such as nursing homes or residential homes. The programme which was initiated in 1964 reduces overcrowding in the institutional facilities, resulting in an improved staff-patient ratio as well as providing a more appropriate setting and better care for the individual.

29. One of the objectives of the programme has been to stimulate community interest and acceptance of the former patients. Diversional programmes adapted to the needs of the residents have been encouraged so that residents may experience a meaningful outlook on life. Some activities have been quite limited while others are more extensive. Increasing attention is being paid to developing this important aspect of the programme.

30. Achievements of the programme indicate reasonable success. More patients have been discharged and placed in outside facilities than had first been anticipated. As of December 31, 1968, 8,370 former patients had been transferred to the programme. Table 19 illustrates the movement of the ex-patients. It is of particular interest to note that 774 residents (9.2 per cent) had to be returned to Ontario Hospitals for various reasons. However, after a period of reassessment and readjustment, it was found that many could be returned to either a nursing or residential home. Consequently, the percentage of failures was considerably less than the 9 per cent referred to above. Allowing for deaths, returns to hospital, temporary absences and discharges, there was a total of 6,124 former patients in nursing and residential homes at the close of 1968.

31. The Ontario Hospitals now have been relieved in large measure of the accumulation of chronic, domiciliary, and institutional cases. However, there still remains approximately 2,000 patients who qualify for placement in outside facilities.

32. (b) **Approved Homes–Halfway Houses**–This programme is administered by the Mental Health Division and involves a number of nursing homes and residential home facilities. Halfway houses accommodate people who are being rehabilitated back into the community but who have not yet been discharged from hospital. These facilities are privately owned and operated, but they are psychiatric hospital approved.

TABLE 19. PATIENT MOVEMENT IN HOMES FOR SPECIAL CARE PROGRAMME (1964–1969)

Placements		
Nursing Homes	6,714	
Residential Homes	1,656	
Total		8,370
Disposition		
Deaths	1,167	
Returned to Ontario Hospital	774	
Absent on Leave	62	
Discharged	243	
In Residence		
Nursing Homes	4,786	
Residential Homes	1,338	
Total		6,124

Source: Public Health Division, Department of Health

SECTION 12

Utilization

33. There are about 11,000 mental patients hospitalized in Ontario at this time, with 1.86 beds per 1,000 representing present total utilization. The present standard for short-term beds is 0.4 per 1,000. The standard for chronic beds is now 1.4 per 1,000, but in five years this should have been reduced to 1.1 and, beyond that, it should be cut to 0.8. Thus, in a few years, 1.2 beds per 1,000 may prove sufficient. Present planning for the mentally retarded is based on 1.5 beds per 1,000.

34. In the last three years or so, 5,000 patients have been moved out of the mental hospitals, after all patients were classified, and 2,600 more are scheduled to be moved when possible. There are about 6,000 now in "homes for special care" under separate jurisdiction (the Department of Health unit dealing with chronic care and rehabilitation).

35. "Short-term care" is defined by the Mental Health Division as up to 12 months, but the average stay in a psychiatric unit is short, and for most patients admitted to mental hospitals the stay is not much longer than 60 days. By 12 months, 90 per cent of these patients have been discharged.

36. It has been suggested that a psychiatric unit in a district or regional hospital is necessary for every 75,000 of the population. While this is a useful way of looking at the total provincial programme, it is hardly adequate in terms of an effective service across the province.

It would seem more desirable to adopt the principle that all regional and district hospitals should have a psychiatric unit, but that this might vary from an arrangement whereby the psychiatric service had access to a few beds only to a large psychiatric unit of perhaps 100 or more beds depending on the geography and on the number of people to be served by the unit.

37. At this point, it is not possible to predict the number of special beds and units required in either the districts or regions of the province, but as it has been demonstrated that psychiatric service can be effectively provided with less than one bed per 1,000 if they are adequately supported by other services, the provision of beds would not seem to be a major problem for the future.

38. Such is not the case, however, insofar as the mentally retarded are concerned, where institutional care seems to be necessary for more than 1.5 cases per 1,000. However, there is need for a critical re-evaluation of the responsibilities of health, education, and welfare for the provision of these institutional facilities.

SECTION 13

Levels of Care

39. The following is a list of the categories of levels of care into which the Mental Health Division classifies patients in psychiatric facilities. (For a list of the types of facilities provided within Ontario and the levels of care provided in each see Attachment 1.)

Category 1. Patients requiring intensive psychiatric care including appropriate psychiatric nursing and utilization of the team of mental health specialists. Intensive programming efforts are also required.

Category 2. Convalescent care requiring specialized psychiatric personnel but not to such an extensive degree as Category 1. Such patients require appropriate programming which may consist of continued treatment, rehabilitative efforts and periodic psychiatric assessment, and specific management.

Category 3. Patients who require medical and nursing care for both physical limitations and psychiatric disability. Such care requires the active involvement of medical staff on a frequent basis, and intensive medical nursing care with psychiatric experience.

Category 4. Such patients require nursing care in a specialized psychiatric facility. Although such care does not require frequent active intervention of a psychiatrist or other member of the mental health team,

specialized psychiatric nursing care in required in view of the patient's disturbed emotional state and specific needs.

Category 5. Those patients who can be placed in a residential or domiciliary setting that require the attendance of specalized mental health personal such as trained psychiatric nurses and periodic review by psychiatrically trained staff. Such patients' behaviour would not be tolerated in more open settings.

Category 6. Such patients may be placed in community nursing homes including the following criteria:

(a) Requires nursing care but not necessarily specialized psychiatric attention.

(b) Social behaviour reasonably acceptable to a community placement.

(c) Readily amenable to those medical and nursing measures usually assigned to a nursing home in the community for other disabilities.

Category 7. Such patients can be placed in a community residential home with the following criteria:

(a) Can be up and about and dressed and requiring little assistance with such measures.

(b) Can go to a dining-room and sit at a table with reasonably acceptable behaviour.

(c) Could go for walks in a neighborhood without causing undue concern.

(d) Is not inclined to wander great distances which may cause danger to the patient's well-being.

(e) May engage in light work although unlikely to be able to support himself in the community.

SECTION 14

Responsibilities for Planning and Administration

40. In the past, community services have not developed in an organized way. As needs were identified by the community, it made its own arrangements, through local agencies such as courts, schools, social agencies. These depended on local pressures and initiative. At the same time, government services were extended further and further down into the community, so that community services could be integrated. Government control really cannot go down to the front line of delivery of service, but it has been felt necessary to study what programmes would be desirable of the community level, and how they could be tied into the government's programme. The Government has considered it necessary to provide services for the mentally ill, since in many instances no one else would assume the responsibility.

41. The Mental Health Division is interested in encouraging local participation. There really has to be a community "strong man" to pull things together at that level. Often the university can do this, sometimes the Medical Officer of Health, the social planning council, or the Mental Health Association. There should be community interest and involvement, but sometimes community interest is not responsible.

42. The mechanism is available for the establishment of psychiatric units in public hospitals, under the operation of local boards. These boards do not always provide the services which are considered necessary. For example, out-patient services should be associated

with all psychiatric units, but these are not always provided. Costs of operating out-patient services were not a problem until current financial constraints; operating costs, including medical salaries, may be met through the Ontario Hospital Services Commission budget mechanism.

Regional Organization

43. The use of the present four planning areas (a relatively small central area surrounding Toronto, and eastern, western, and northern areas) is questionable. Despite past experience, planning should be decentralized and the growth of service should be from the local level upwards rather than being imposed and developed from central levels.

44. Therefore, the desirability of the mental health programme fitting into the pattern of regionalization being developed for other health services should be stressed. The role of the Health Sciences Centre is considered very important in a system of regional organization – in patient identification and assessment, in treatment, in education, and in continuing education throughout the region.

45. Through a system of regional organization, other issues might be resolved. Regional councils could develop long range plans for all types of health care programmes and facilities, priorities could be established for renovation and building, some sections of old, poorly located institutions could be phased out over a period of time, and facilities for the physically and mentally ill integrated, or at least brought into closer relationship. (It is recognized that some separate institutions will probably always be necessary – e.g., for the criminally insane, or for the emotionally disturbed child.)

46. Through a system of regionalization, more effective use could be made of available personnel and financial resources, (e.g., psychiatric unit staff could provide consultative services to other medical men in the area).

47. Basic to the concept of regionalization is community participation. This should occur not only through the regional organization structure, but also through the establishment of local boards responsible for the operation of mental health facilities in a way similar to that in effect for public general hospitals. (It was realized that difficulties could exist in persuading people to serve on these boards, especially if the hospital were large and served a wide area,

and that perhaps such a change would have to be instituted over a period of time.)

Planning Procedures

48. Review should be made of the standards, indices, methods, and procedures involved in the planning process. Some of the items suggested for review are:

    (a) the standards related to facility location and to bed needs (e.g., 0.4 beds for 1,000 population for short term psychiatric needs and the related policy concerning placement of a psychiatric unit in a public general hospital where the service area population is 75,000 except when a provincial psychiatric hospital is situated in the same city);

    (b) the methods used to identify needs, especially for new types of facilities, to assess existing facilities, to establish priorities;

    (c) the procedures involved at all stages of planning from approval-in-principle through detailed plan review to final approval.

    (d) the arrangements related to the planning process which exist among the Department of Health, the Department of Public Works, and the O.H.S.C., and the role of the political process in planning.

49. Better planning is necessary in relation to overall programmes (e.g., to keep the individual out of hospital rather than institutionalized, through the development of community programmes) and in relation to individual facilities (e.g., to ensure greater flexibility in design so that programmes can be changed, or to create a more pleasant environment in the out-patient department).

SECTION 15

Relationships with other Agencies and Facilities

50. One way in which liaison is maintained with other health and related facilities and with the public is through liaison committees. A Professional Liaison Committee has been set up, with representation from five professional associations—Psychiatrists, Psychologists, Registered Nurses, Physiotherapists, and Occupational Therapists. The representatives meet with senior staff of the Mental Health Division four times a year to review current philosophies and programmes thus providing a forum for the interchange of ideas.

51. Another liaison committee has been established with the five heads of the Departments of Psychiatry in each of the Health Sciences Centres, in order to co-ordinate the further development of training programmes in relation to service programmes.

52. The Mental Health Division gets a feedback of local and professional opinion through its consulting staff which becomes acquainted with local problems, as also does the staff concerned with the planning for new or expanded facilities, or with the budget review process.

Facilities for the Retarded

53. Relationships between the agencies providing programmes and facilities for the retarded (primarily the Department of Health, the Department of Education, and the Ontario Association for the

Mentally Retarded) are not well defined. Often the problems are not medical, but are educational and are related to vocational training. The problem is complicated by the facilities operating under *The Boarding Homes Act* or *The Private Schools Act,* where no control exists related to standards of care.

54. An Interdepartmental Committee on Mental Retardation has been set up, comprised of representatives of the Department of Health, Social and Family Services, and of the Ontario Association for the Mentally Retarded. This committee has only advisory powers but it does discuss new facilities and programmes.

Alcoholism and Drug Addiction

55. Special units have been developed in psychiatric hospitals, some in collaboration with the staff of the Alcoholism and Drug Addiction Research Foundation and some without. Liaison is maintained with Alcoholics Anonymous.

56. Among the problems are the fact that the Foundation can be selective in the patients it treats, while the psychiatric hospital tends to become a dumping ground. The Foundation has expressed an interest in putting its staff into psychiatric facilities to supervise the alcoholism and drug addiction programme, but it also has proposed the development of a separate, unrelated system of clinics and farms. The Foundation is interested in research, perhaps, more than service.

57. Better co-ordination and liaison between the Department of Health and the Alcoholism and Drug Addiction Research Foundation is certainly necessary but the desirability of establishing separate programmes for these patients is seriously questioned. The difficulties in establishing effective clinical and research programmes and recruitment of skilled staff are continuing problems with these units.

SECTION 16

Comments

58. As Psychiatry is a specialty of Medicine, psychiatric services should presumably be organized to reinforce and complement other health services. Four levels of service can be identified within a province-wide system of psychiatric services. They are, consultation, acute care, special regional services, and highly specialized provincial services.

59. For optimum efficiency and quality of care, it is essential that there be highly developed vertical integration between the levels. Equally important is the horizontal integration of each level with related programmes and facilities, i.e., education and welfare.

60. The **first level** of psychiatric services consultation can be considered under many headings including case consultation, programme consultation, and community services consultation. Of these, the first can be considered as being in the area of psychiatric treatment services, and programme and community services more appropriately under the heading of "Mental Health Services." Case consultation should be available to front line personnel, of which the personal or family physician will be the most prominent, but should also be available to public health nursing, social agencies, school systems, and so on. The provision of this level of service does not require any special psychiatric facilities though office space would be required for the specialized personnel at the point where the service is provided, i.e., doctor's office, school, social agency, public health office. It is suggested that those committees of the

Ontario Council of Health dealing with personnel, delivery of service, and so on, develop activities and incentives (including financial incentives) which would encourage a reasonable distribution of psychiatrists across the province to fill the consultation function.

61. It is apparent that present training programmes for psychiatrists equip them, to some extent, for this psychiatric consultation role, but only to a very limited extent, if at all, to provide programme and community organization consultation. This matter should be brought to the attention of the Education Committee of the Ontario Council of Health.

62. It is difficult to give figures regarding the desirable distribution of psychiatrists to provide consultation services. At various times and in various places it has been suggested that one psychiatrist for 50,000 people, one for 25,000 or even one for 5,000 people would be necessary. In all probability the requirement varies greatly in terms of geography, population density, and the sophistication of both the health services and the population at large. If one looks at rural Nova Scotia, it would appear that at least one psychiatrist is necessary for every 10,000 to 15,000 people and in the City of Montreal there are usually qualified psychiatrists and residents in training at a rate of about one per 5,000 of the English speaking population.

63. Another way of looking at this problem would be to consider the relationship of a psychiatrist as a specialist to general practitioners and other physicians in the community. It would appear that a psychiatrist cannot relate effectively to more than 10 to 15 physicians, and that such a number of physicians will keep a psychiatrist more than busy.

64. Using indices such as those above it is apparent that there is a great shortage of psychiatrists and, of course, there is a maldistribution of psychiatrists. To accomplish anything like the objectives envisaged here would require two to three times the number of psychiatrists presently available and the more than doubling of the existing training programmes. Such an approach would be necessary, however, if we are to reduce the number of beds presently occupied by psychiatric patients, and in terms of both capital and operating costs for the Province as a whole the cost of these consultation services would be more than justified financially.

65. The reason for stressing this first level of psychiatric service is to give emphasis to the way in which the availability and distribution of such services within the community can affect the need for physical plant (in particular beds) and to emphasize that the wider provision of such services can materially reduce the number of beds for psychiatric patients, as now demonstrated in Saskatchewan, Kansas, Great Britain and many other places. This first level of psychiatric services must provide "in-service" education to the front line personnel to make them more effective in coping with this problem.

66. The **second level** of service required is for the acute care of disturbed patients. Too often such patients either go without adequate care or are looked after by local police forces. It should be emphasized that the acute care of patients with psychiatric disturbances is not particularly difficult. This is mainly a matter of medical management and nursing care rather than of facilities. Every general hospital should be able to admit a disturbed patient as it would an accident case, and should be able to provide treatment as it would for surgical shock. This is a matter of the administration of drugs, the maintenance of fluid in-take, and so on. The present inability of hospitals to do this may be related to a continuing prejudice with respect to mental illness, inadequate training of physicians and nurses, and the inadequacy of arrangements for the care of such cases after the acute episode is over. This level must be functionally integrated with the first and third levels of care, with prescreening and effective follow-up.

67. The suggestion that each general hospital should be able to care for psychiatric emergencies has very few implications in terms of physical plant. It has been amply demonstrated that such patients can be cared for in the unit provided for other emergency cases, provided that medical and nursing staff are adequately trained and medications are used effectively. To ensure the development of the acute level of care the consultation services previously mentioned are critical.

68. Local general hospitals must be reinforced by psychiatric units in appropriate general or special hospitals in the various districts and regions of the province. Through such arrangements it will be possible for patients, who have received the first and second level of treatment, to be appropriately investigated and referred to further necessary treatment either in the community or at a more highly specialized psychiatric service.

69. Of great importance here, in order to prevent the "silting up" of the psychiatric facility, is the relationship of the hospital and medical services in general to other personal care services in the community, particularly those presently under the jurisdiction of welfare (e.g., housing and various means of support) as patients tend to become transient and may be unemployable and the absence of suitable facilities for children (e.g., group houses) leads to undesirable forms of institutionalization.

70. At the **third level**, the more highly developed psychiatric facilities should be provided on a regional basis either located in the general hospital at the regional level or in special regional facilities. Included in these special regional services would be special facilities for the continuing investigation and care of all age groups, and the investigation and programming for emotionally disturbed children and the mentally retarded. These third level services should be a major centre for clinical and operational research and have freedom to redirect methods of patient care on a pilot basis.

71. At the **fourth level** of service, certain very highly specialized services would be provided for the entire province (e.g., for the criminally insane and the dangerous mentally ill) and should be developed on a province-wide basis. At this stage, in Ontario, it is doubtful that any services other than that for the criminally insane, and the dangerous mentally ill, should be on a province-wide basis, but rather that special services should be at the regional level.

72. The planning of a highly centralized psychiatric services and mental health system based on the present four planning areas (a relatively small central area surrounding Toronto, and eastern, western, and northern areas) is questionable. Despite past experience, planning should be decentralized and the growth of service should be from the local level upwards rather than being imposed and developed from central levels.

73. Therefore, the desirability of the mental health programme fitting into the pattern of regionalization being developed for other health services should be stressed. Through a system of regional organization, other issues might be resolved. Regional councils could develop long range plans for all types of health care programmes and facilities, priorities could be established for renovation and building, some sections of old, poorly located institutions could be phased out over a period of time, and facilities

for the physically and the mentally ill integrated, or at least brought into closer relationship. Through a system of regionalization, more effective use could be made of available personnel and financial resources, (e.g., psychiatric unit staff could provide consultative services to other medical men in the area).

74. Community participation is basic to the concept of regionalization. This should occur not only through the regional organization structure, but also through the establishment of local boards responsible for the operation of mental health facilities in a way similar to that in effect for public general hospitals. The rigidity of employment practices, use of personnel, etc., which are built-in features of the provincially operated system, are antipathetic to the development of imaginative and creative programmes responsive to and integrated with community mental health needs. (It is realized that difficulties could exist in persuading people to serve on these boards, especially if the hospital were large and served a wide area, and that perhaps such a change would have to be instituted over a period of time.) The type of programme envisaged in this report would require effective integration of psychiatric services in all health department activities at the provincial, local, and regional levels. It would appear that the required mental health or psychiatric services at the provincial level might well consist of nothing more than psychiatric consultants attached to the programmes of the Provincial Health Department.

75. Better planning is necessary in relation to overall programmes (e.g., to keep the individual out of hospital rather than institutionalized, through the development of community programmes) and in relation to individual facilities (e.g., to ensure greater flexibility in design so that programmes can be changed).

76. Review should be made of the standards, indices, methods and procedures involved in the planning process. Some of the items suggested for review are:

    (a) the standards related to facility location and to bed needs (e.g., 0.4 beds for 1,000 population for short term psychiatric needs and the related policy concerning placement of a psychiatric unit in a public general hospital where the service area population is 75,000 except when a provincial psychiatric hospital is situated in the same city);

    (b) the methods used to identify needs, especially for new

types of facilities, to assess existing facilities, to establish priorities;

(c) the procedures involved at all stages of planning, from approval-in-principle through detailed plan review to final approval;

(d) the arrangements related to the planning process which exist among the Department of Health, the Department of Public Works, and the O.H.S.C., and the role of the political process in planning.

77. The financing of mental health and psychiatric services and the related capital grants system should be integrated fully into other health care programmes. There seems to be no more reason for the continued segregation and isolation of costs for mental health services than there would be for obstetrical, surgical or paediatric services. Indeed, the present separation and designation of costs is detrimental to the full development of psychiatric services, e.g., general hospitals have been allowed an increase of 8.5 per cent in their budgets for 1969, community psychiatric hospitals 6 per cent, and it is understood that the facilities operated directly by the Province will not be allowed any increase in personnel during the coming year. Surely, all treatment services should be treated equally and the present methods are bound to result in an increased disparity in both the quality and quantity of care provided to psychiatric patients as compared to persons suffering from other illnesses.

TABLE 20

PSYCHIATRIC UNITS IN PUBLIC GENERAL HOSPITALS

Location	Name	PSYCHIATRIC FACILITIES				
		Total Beds	Present Beds	Future Beds	Est'd Year Available	Out-patient Facilities
Barrie	Royal Victoria	214	Nil	34	1968	X
Belleville	Belleville General	258	Nil	40	1968	X
Brampton	Peel Memorial	255	21	40	1969	
Brantford	Brantford General	497	36	50	1970	
Burlington	Joseph Brant Memorial	228	Nil	35	1969	
Chatham	Public General	274	Nil	30	1968	X
Cooksville	South Peel	395	40	40	1968	
Cornwall	Cornwall General	222	Nil	30	1969	X
Don Mills	North York General	—	Nil	83	1968	
Etobicoke	Etobicoke General	—	Nil	40	1970	
Fort William	McKellar General	363	Nil	24	1968	X
Hamilton	Hamilton Civic (Barton)	638	30	30		
Hamilton	St. Joseph's	740	39	39		X
Kingston	Kingston General	596	36	36		X
Kitchener	Kitchener-Waterloo	441	17	60	1969	X
London	St. Joseph's	594	41	41		
London	Victoria	934	49	49		
Newmarket	York County	257	22	30	1970	X
Niagara Falls	Greater Niagara General	399	36	36		X
Oshawa	Oshawa General	737	Nil	24	1970	
Ottawa	Ottawa Civic	1076	40	40		X
Ottawa	Ottawa General	622	34	34		X
Pembroke	Pembroke General	156	Nil	25		
Peterborough	Peterborough Civic	347	26	66	1970	X

TABLE 20 (cont'd)

PSYCHIATRIC UNITS IN PUBLIC GENERAL HOSPITALS

		PSYCHIATRIC FACILITIES				
Location	**Name**	**Total Beds**	**Present Beds**	**Future Beds**	**Est'd Year Available**	**Out-patient Facilities**
Sarnia	Sarnia General	315	24	24		X
Sault Ste. Marie	The General	285	20	20		
St. Catharines	Hotel Dieu	307	21	21		
Scarborough	Scarborough Centenary	257	44	100	1968	
Scarborough	Scarborough General	495	Nil	20	1968	X
St. Catharines	St. Catharines General	482	22	53	1968	X
Sudbury	Sudbury General	329	31	31		
Toronto	St. Joseph's	627	25	25		
Toronto	St. Michael's	894	30	30		
Toronto	New Mt. Sinai	369	Nil	40	1970	X
Toronto	Queensway General	334	20	40	1971	X
Toronto	Wellesley	454	29	29		
Toronto	Western	861	39	39		
Toronto	Women's College	280	20	35	1969	
Weston	Humber Memorial	313	20	85	1970	
Willowdale	North York Branson	436	24	24		
Windsor	Hotel Dieu	486	35	35		
Windsor	Metropolitan	353	30	30		
London	University Hospital	—	Nil	25	1971	
Richmond Hill	York Central	126	Nil	30	1970	
Welland	Welland County General	341	Nil	35	1969	X
Oakville	Oakville-Trafalgar	333	Nil	35	1971	
Kingston	Hotel Dieu	319	18	20		
		19,239	919	1,782		

TABLE 21

COMMUNITY PSYCHIATRIC HOSPITALS

Location	Name	No. Beds
Guelph	Community Psychiatric Hospital	Not Available
Hamilton	Community Psychiatric Hospital (Hamilton Health Association)	Not Available
Ottawa	Community Psychiatric Hospital (Royal Ottawa Sanatorium)	80
Sudbury	Community Psychiatric Hospital (Sudbury & Algoma Sanatorium)	80
Toronto	Community Psychiatric Hospital (C. M. Hinks Treatment Centre)	18
Windsor	Community Psychiatric Hospital (I.O.D.E. Hospital)	80

TABLE 22

PSYCHIATRIC HOSPITALS

(formerly called Ontario Hospitals)

Location	Name	No. Beds
Brockville	Brockville Psychiatric Hospital	1,074
Goderich	Goderich Psychiatric Hospital	230
Hamilton	Hamilton Psychiatric Hospital	1,451
Kingston	Kingston Psychiatric Hospital	935
London	London Psychiatric Hospital	635
New Toronto	Lakeshore Psychiatric Hospital	540
North Bay	North Bay Psychiatric Hospital	720
Owen Sound	Dr. MacKinnon Phillips Hospital	218
Penetanguishene	Penetang Psychiatric Hospital	671
Porcupine	Northeastern Psychiatric Hospital	250
Port Arthur	Lakehead Psychiatric Hospital	1,080
St. Thomas	St. Thomas Psychiatric Hospital	1,822
Thistletown	Thistletown Hospital	113
Toronto	Queen Street Mental Health Centre	710
Whitby	Whitby Psychiatric Hospital	1,143
Woodstock	Ontario Hospital	1,518

TABLE 23

FACILITIES FOR THE RETARDED

(a) Regional Hospital Schools

Location	Name	No. of Beds
Cedar Springs	Ontario Hospital School	1,000
Orillia	Ontario Hospital School	1,000
Palmerston	Midwestern Regional Children's Centre	240
Smiths Falls	Rideau Regional Hospital School	2,038
	TOTAL	5,635

(b) Specialized Training Facilities

Location	Name	No. of Beds
Aurora	Ontario Hospital	200
Cobourg	Ontario Hospital	320
Edgar	Adult Occupational Centre	260
London	Children's Psychiatric Research Institute	100
Toronto	Mental Retardation Centre	24
	TOTAL	904

TABLE 24

REGIONAL CENTRES FOR CHILDREN (1968)

LOCATION	Associated Facility	No. of Children's Beds
Ottawa	Community Psychiatric Hospital	18
Kingston	Kingston Psychiatric Hospital	16
Toronto	Thistletown Hospital Clarke Institute Mental Retardation Centre	135
Hamilton	Community Psychiatric Hospital	0
London	Children's Psychiatric Research Institute	100
Windsor	Community Psychiatric Hospital	0
Sudbury	Community Psychiatric Hospital	16
Port Arthur	Lakehead Psychiatric Hospital	135
Total		420

TABLE 25

CANADA: PSYCHIATRIC HOSPITAL CARE, BY PROVINCE – 1966

	Beds		Admissions		Days of Care	
	Number	per 1,000 pop.	Number	per 1,000 pop.	Number	per 1,000 pop.
Canada	65,238	3.26	56,939	2.84	23,797,230	1188.97
Newfoundland	826	1.68	878	1.78	299,589	607.69
Prince Edward Island	398	3.65	530	4.86	124,460	1141.83
Nova Scotia	2,492	3.30	2,710	3.58	796,825	1054.00
New Brunswick	2,016	3.27	1,823	2.95	796,698	1291.24
Quebec	18,353	3.17	17,405	3.01	7,261,952	1256.18
Ontario	22,910	3.29	19,545	2.81	8,070,847	1159.44
Manitoba	3,095	3.21	1,441	1.50	1,151,368	1195.61
Saskatchewan	2,963	3.10	1,030	1.08	1,086,814	1138.03
Alberta	5,841	3.99	4,027	2.75	2,020,516	1381.08
British Columbia	6,344	3.39	7,550	4.03	2,188,161	1167.64
Yukon	–		–		–	
Northwest Territories	–		–		–	

TABLE 26

UNITED STATES: PSYCHIATRIC HOSPITAL CARE, BY REGION – 1966

	Beds		Admissions		Days of Care*	
	Number	per 1,000 pop.	Number	per 1,000 pop.	Number	per 1,000 pop.
United States	639,041	3.26	451,178	2.30	212,257,468	1083.29
New England	54,336	4.83	40,624	3.61	17,611,384	1566.29
Middle Atlantic	178,828	4.87	74,064	2.02	61,094,798	1664.48
South Atlantic	84,446	2.90	64,962	2.23	28,264,498	971.12
East North Central	139,634	3.60	94,573	2.44	45,716,870	1180.21
East South Central	34,279	2.66	30,118	2.34	11,323,211	878.11
West North Central	43,714	2.74	32,705	2.05	14,056,892	882.30
West South Central	33,930	1.81	39,696	2.11	11,133,621	592.31
Mountain	9,991	1.29	17,610	2.28	3,227,343	418.26
Pacific	59,883	2.41	56,826	2.29	19,846,424	800.03
					212,275,041	
					(17,573)	

* Calculated by multiplying rated beds by occupancy rate. Total for U.S. calculated independently – hence discrepancy.

Part III

HEALTH FACILITIES IN RELATION TO EDUCATIONAL AND RESEARCH PROGRAMMES

SECTION 17

Manpower Training

1. There is an increasing need for health manpower of all types. This implies expansion of programmes at undergraduate, graduate degree, and postgraduate professional levels of education at the universities, and of training programmes at colleges of applied arts and technology.

2. One of the most important aspects of undergraduate and postgraduate education is the environment for training. First, it should offer the opportunity for clinical experience under supervision, with graded responsibility according to competence and level of training.

3. Secondly, the current dependence on active treatment general hospitals as the primary base for training health personnel should be altered to an environment which is more representative of the type of clinical situations in which the health professionals may be expected to serve. In particular, emphasis should be given to the development of clinical training in the community setting and in clinics where care is given to ambulatory patients.

4. Thirdly, the advantages of relating the training programs for several health professions may be best achieved by bringing instructors and trainees together in relation to clinical problems which require specific contributions from each profession. In concentrating the teaching programmes at one site, care must be taken to ensure that the extent of involvement of individual

patients in the teaching programme does not exceed their tolerance, that the level of supervision is adequate to ensure exemplary standards of care, and that the dignity and feelings of the patients are fully respected.

5. The current trends in academic programmes for the health sciences at Ontario universities have been summarized in the 1966 Report to the Committee of Presidents of the Universities of Ontario entitled "The Health Sciences in Ontario Universities: Recent Experience and Prospects for the Next Decade." In general, the concept of health sciences with responsibility for training several health professions has been accepted or is under consideration at each of the five medical schools in Ontario. The basis for this has been the prospect of health care being delivered in the future by a team of special personnel rather than individually by the physician.

6. It was noted that the need to train personnel in several other health professions was as urgent as the expansion of medical education, and that greater success might be achieved in integrating the activities of the various health professions if they are educated together and if opportunities are created to permit operational research on professional role differentiation and team work in the delivery of health care. Furthermore, although each of the health professions requires certain specific facilities for its educational programmes, all may share the most expensive of these facilities, the hospital and ambulatory clinics for patient care.

7. The Report also recognized that large numbers of health personnel will receive their professional education or technical training in institutions other than the university. Some training programmes will continue to be related to individual health care institutions but others may emerge in the colleges of applied arts and technology. These programmes may have more flexible admission requirements, shorter duration and a more applied approach to learning than would be likely if they were developed under direct university auspices. If possible, however, they should be related to university health sciences centres in order to capitalize on the advice, specialized manpower and teaching resources available through the university. Furthermore, to facilitate upward professional mobility, the curriculum at the colleges of applied arts and technology should be such as to permit a small proportion of talented graduates to enter with advanced standing university health sciences programmes.

SECTION 18

Research

8. There is need for basic, applied, operational, and developmental research in relation to the health sciences and to the system of delivery of health care. It is accepted that the basic and applied research in the health sciences is sponsored primarily at the universities but it has only been recently appreciated that in order to facilitate the application of scientific advances to the delivery of health care, an intimate geographic relationship of research and service is required.

9. There is also an advantage in encouraging the development of operational research on the delivery of health care in academic centres; first, because the personnel required to carry out these studies may be more readily attracted to such a setting, and secondly, because the results of the studies may be fed back more rapidly to the educational programmes for the production of health manpower.

SECTION 19

Planning Educational and Research Facilities

10. Planning for the expansion and renovation of university programmes in the health sciences was greatly stimulated in 1964 by the announcement by Premier Robarts of the intention of the Province of Ontario to upgrade its facilities for health science education and research and by the establishment in 1965 of the Federal Health Resources Fund. Two impediments, however, have delayed the realization of these plans. First, some of the initial planning was done on an institutional basis without reference to area wide needs or programmes proposed by neighbouring institutions serving the same university. Secondly, the forecast of expenditures required to bring the proposed plans to fruition has proved to be nearly double the initial estimates and certainly far in excess of the financial assistance available to the Province on a matching grant basis from the Health Resources Fund.

11. The delay occasioned by the current fiscal constraints is not altogether detrimental since it has forced each centre to review its plans in broader perspective and to define priorities more precisely. However, further delay in the provision of sensibly planned facilities for the health sciences represents a serious threat to the future system for the delivery of health services from the standpoints of quantity, quality, and distribution. The importance of a major investment now in university health sciences programmes can only be justified in terms of the substantial long-range benefits which will be made possible by the unique role of these centres in augmenting the supply of health manpower, catalyzing

regional planning of specialized health services, shaping new approaches to the delivery of health care, and influencing the quality and economy of health services through applied and operational research.

12. Planning of health sciences facilities has been hampered by a number of problems. First, there has been uncertainty about the role and responsibilities of the university and the health facility, especially in the case of active treatment hospitals used for teaching programmes. The conflict of objectives which may be more apparent than real is largely responsible for the creation of "University Hospitals." Secondly, there has been a relative lack of interest of universities in using ambulatory and chronic care facilities for their teaching programmes in spite of the importance of this type of experience in the training of health personnel. Thirdly, there have been no satisfactory standards or indices of the type and amount of space required for teaching and research programmes in the health sciences centres. For example, the number of active treatment hospital beds required cannot be established by an arbitrary ratio of ten beds per medical student in the graduating class but rather should be decided by the scope of responsibility at all levels of education for the several health professions and by the relationship of the clinical teaching and research programmes to regional specialty units. While qualitatively similar, the five health sciences centres in Ontario may be expected to be quantitatively different in the responsibilities which they assume.

13. Although university hospitals and health sciences centres are now being considered as individual institutions, it is neither desirable nor feasible to develop all the specialized facilities required by a modern health sciences centre at one site and in most centres it has been the tendency to establish university-directed units in several hospitals in accordance with the natural potential of each institution to provide certain aspects of specialized service.

14. Although many practical difficulties are foreseen, the objective is to link the special programmes of education and research in the health sciences with a regional network of specialized health services in the area in which the health sciences centre is located, minimizing duplication of resources and providing an excellent base for continuing education and contact with the practising health professions. The undesirable competition between hospitals, and the duplication of facilities that resulted from the attempt

to attract medical interns and residents, can be expected to be substantially reduced by the ruling of the Royal College of Physicians and Surgeons of Canada that, from 1970, this aspect of postgraduate education leading to higher professional qualifications will be under the direction of University Faculties of Medicine.

15. No health sciences centres have been established or projected for Northern Ontario. In view of the apparent influence of these centres on the supply of health manpower and the quality of health services, it is important that the major centres of population in Northern Ontario be provided with alternative solutions or working relationships with one or more health sciences centres in Southern Ontario.

Part IV
PLANNING, DESIGN, AND CONSTRUCTION OF HEALTH FACILITIES

SECTION 20

Planning

General

1. Other Parts of this background paper refer to the administrative organizations responsible for the creation and maintenance of physical resources to support health care programmes.

2. Part IV deals briefly with the role of such organizations related to physical resources. In addition, it examines the current state of the various processes of planning, design, and construction; it describes methods of working and approval and comments on apparent problems and trends.

Definitions

3. Planning is considered for the purpose of this report to be the identification of new, augmented or transformed requirements within the broad range of health service and health-related programmes. A distinction will be made herein between programme planning and project planning. Programme and project planning may be done with correspondingly greater attention to organizational detail at the national, provincial, regional, district, and individual health facility level of authority.

4. Initial programme planning studies should culminate in a proposed long range master programme for a defined grouping of services and for an extended period. This programme should

comprise a statement of progressive objectives on a time-phased basis. For each phase it should include:

(a) the purpose of the programme;
(b) a functional programme, being a statement of the services to be performed;
(c) an organizational programme being a statement of the manpower requirements;
(d) an inventory of existing or proposed facilities (in terms of block areas or space groupings);
(e) an estimate of the capital and operational costs;
(f) a statement of the proposed method of financing.

Current Status

5. Primary responsibility for programme (overall) planning and for approval of a project planning rests with the Provincial Government and its delegated agencies. Initiation of programme planning for the several categories in the spectrum of health service facilities can be traced to several separate authorities, such as:

(a) the Public Health Division;
(b) the Mental Health Division;
(c) the Ontario Hospital Services Commission;
(d) other government agencies including the Provincial Departments of Social and Family Services, Education and University Affairs, as well as to Federal Departments of Health and Welfare, Defence and Veteran's Affairs, and to certain private enterprises. These agencies are involved in varying degrees (where the health component may be only a part of the function).

6. Interdepartmental committees exist, but their duties appear to be co-ordination and liaison, rather than joint master planning.

7. Public hospitals, comprising the broad range of health services supported by the national hospital insurance programme, account for the largest part of the annual construction cost of Ontario health service facilities. Notwithstanding government master planning and planning studies the onus of originating and performing hospital planning projects falls largely on the individual hospital board of directors. In recent years, project planning has often included a measure of programme planning. Where undertaken, it has been accomplished largely by private consulting firms, e.g., hospital planning consultants–management consul-

tants—specially qualified architectural firms—specializing planning consultants (e.g., food services, laboratory services).

8. Only occasionally is planning performed by the staff of the individual hospital boards, although unquestionably, hospital boards, hospital management, medical and nursing directors, and technical personnel become deeply involved in time-consuming committee work and in an advisory capacity to private consultants.

9. The number and quality of comprehensive programmes and project briefs submitted to the O.H.S.C. for approval, in support of new or renovated facilities, has been increasing. According to O.H.S.C. recommendations, approval of major hospital projects is ordinarily required in several stages as follows:

Programme Planning

Stage 1. A. Application by the hospital board to undertake a planning project.

B. Application by the hospital board to engage private consultants.

Stage 2. A. Role Study:

1. Define the present and future needs of the region or area, district, and community, and overall organization and integration of the health care services required to meet them;

2. Define the range of services and programmes (including teaching and research) that the hospital, in keeping with overall organization and integration, would be expected to provide for a prolonged period, in the order of 15 to 20 years.

B. Master Programme:

1. In keeping with 2A-2 above, a statement of the hospital's immediate and long range objectives;

2. Identification and interpretation, in narrative form, on a time-phased basis, of all major programmes deemed necessary to meet these objectives.

C. Approval of the Role Study and the Master Programme.

Project Planning

Stage 3. A. Feasibility Studies:

1. Evaluation of existing buildings (where applicable);

2. Evaluation of land:
   Total area in use, available and/or required;

3. Method of financing.

B. Preparation and approval of Master Plan.

Stage 4. A. Immediate Programme (Detailed analysis of that part of the Master Programme to be implemented at this time):

1. Forecast of service and departmental workloads;

2. Inter- and intra-departmental and service relationships;

3. Operational policies and procedures;

4. Organization and staffing.

B. A Narrative Description of the following systems: (design proposal)

1. Transportation (materials and personnel);

2. Communication;

3. Mechanical and electrical;

4. Structural.

C. Definition of Space Needs. (space inventory)
   Dimensions of facilities which are repetitive or which have functions that are special or unusual.

Stage 5. Approval in principle of the Immediate Programme.

Comments

10. There is evidence that initiation and conduct of functional programme planning, as presently conducted, results in:

    (a) duplication of planning effort;
    (b) an ever-increasing delay between first steps and project completion (as much as six to eight years) with problems resulting in continual adjustment to changing needs and new trends;
    (c) increasingly heavy demands on specialized planning skills and on the time of highly trained health service personnel;
    (d) increasing and usually unjustifiable competition between facilities for available public and private funds;
    (e) considerable planning expenditures made in support of competitive claims, resulting in duplication of planning, overlapping of services and facilities, and variance with overall planning concepts.
    (f) a multitude of submissions and meetings (O.H.S.C. officers point out that submissions do not usually contain, at the outset, all information needed for approval).

11. Approval agencies experience problems in co-ordinating individual projects submitted for approval, or for licensing, with overall regional (or provincial) long range master programmes and objectives. This comment applies to the O.H.S.C. with respect to hospitals and, in an even greater degree, to the Departments of Health and of Social and Family Services with respect to domiciliary facilities.

12. There is evidence that hospital boards are frustrated by delays, which cost time and money, in their attempts to obtain O.H.S.C. approvals. Also, that plans and projects based on the advice of O.H.S.C. specialist consultants appear, at times, to be in conflict with the conditions of approval.

13. Estimates for long planning tend to concentrate on over-simplified units of measurement, for example, the hospital bed. The use of more precise indicators, such as contributing population, age and sex distribution, out-patient clinic visits, diagnostic or treatment procedures, units of laboratory work, etc., would more

accurately describe consumer needs and would make planning of physical resources more sensitive to changing patterns or health care.

14. An extra degree of planning effort is warranted at all levels to counter-rising plant operating costs, to reduce obsolescence and to maintaining or alter physical plant suitable to changing and improved programmes. A new emphasis should be placed on diversity, expandibility, and flexibility to adapt to changing programmes, with the object of reducing costs related to operations, maintenance, and renovations of physical plant.

SECTION 21

Design

Definition

15. Design involves the transformation of the planning studies into a specific building project, or a phased series of projects, which may be called the design proposal and may take various forms, for example:

    (a) Descriptions of basic systems;
    (b) Lists of space components with their estimated areas or dimensions;
    (c) Schematic or phased site utilization proposals illustrated with drawings or three-dimensional block models;
    (d) Schematic plans at small scale showing floor arrangements and departmental relationships;
    (e) Preliminary capital and operational costs estimates*;
    (f) Exterior and interior "artist conceptions";
    (g) Small or full scale mock-ups;
    (h) Preliminary proposal plans showing room arrangements and equipment locations;
    (i) Construction contract drawings and specifications for all trades.

    * (At later stages estimates may be progressively more detailed and more precise).

Current Status

16. For general hospitals, proposals for the translation of the approved programmes into a "physical project proposal," are currently accomplished by groups of design consultants, usually architects and engineers working as a design team. In the case of provincial psychiatric hospitals, hospital schools and facilities for the profoundly handicapped, this work is usually performed by the provincial Department of Public Works. It produces construction documents which will meet the approval of the directors of the particular institution and of the regulatory bodies.

17. Very large projects are occasionally placed, on a contractual basis, under the control of a project management consultant, who supervises and directs the several stages of planning, design, construction, equipping and initial operational training for the project.

18. Special studies and research involving design innovation, requirements research, demonstration projects, operational research, evaluation of design innovations, of new systems and new equipment, are presently carried out in a modest scale by design firms, as well as by individual institutions and by government agencies. There is no present evidence of co-ordination of these investigations and research projects as they relate to health services in Ontario. Very few such projects publish the results of special studies.

19. The O.H.S.C. recommendations for the stage of design approval are as follows:

(Continued from Planning Process Stages 1-5 listed in Section 20 – Planning)

Project Design

Stage 6. A. Block schematics (to scale).

B. Preliminary statement of cost estimates.

C. Approval of immediate project.

Stage 7. Submission and approval of sketch plans (scales 1:16 or 1:8).

Stage 8. Submission and approval of outline of specifications and applications for Capital Financial Assistance.

Stage 9. Submission and approval of Working Drawings, Specifications, and Tender Documents.

Stage 10. Submission and approval of Final Statement of Cost Estimates (results of competitive tendering tabulated) and recommendation for contract agreement.

Comments

20. The process of design has become increasingly complex, with a resulting increase in the design consultant specialties, and in the number of trade specialties in the construction industry for which design must be performed. For control of capital costs, it should be required by regional authority that projects are uniformly developed and costed by competent design services at each approval stage, thus permitting a more accurate budgeting of financial resources. For control of future operational costs, it should be required that design engineers provide carefully considered estimates of energy and fuel costs to permit management to make decisions at an early stage that will keep operating costs, including labour, as economical as possible.

21. The multiplication of available systems of communication, transportation, environmental control, medical and diagnostic equipment, and specialized service equipment (food service, laundries, etc.) can result, in some cases, in wasteful accumulation of overlapping choices, such as overgenerous provision of elevators, conveyors, dumb-waiters and pneumatic tubes, without adjustment for their complementary utilization. In other cases, sophisticated equipment is selected which is wastefully or insufficiently used, because it is beyond either the competence of the technical personnel available or the needs of the programme; or labour-saving devices (e.g., vertical conveyors) are provided which do not save enough labour to justify the installation.

22. There is a continuing disparity between actual plans submitted and generally accepted ideas of good design. Noteworthy deficiencies are:

(a) Economical relationship between capital investment and plant operating costs;

(b) Design for the reduction and control of institutionally acquired infections by means of isolation, containment, and facilities for aseptic care;
(c) Control and modulation of room environment for therapeutic and diagnostic reasons;
(d) Optimum use of trained personnel by optimum space relationships, efficient communications, traffic and movement routes, and equipment commensurate with needs and skills;
(e) Unobtrusive and efficient control of visitors for best health care management;
(f) Tactful and efficient surveillance of staff;
(g) Abatement of unnecessary noise;
(h) Surfaces and systems ammenable to high standards of aseptic maintenance and sanitary housekeeping and operational economy;
(i) Safety and comfort of patients and staff (fire and accident control or prevention, social and occupational well-being);
(j) Flexibility of building fabric and systems to adapt to changing programme (for long term usefulness);
(k) Clean air, including the concept of continuous dilution and scavenging ventilation for critical locations.

23. The committee identified some characteristic problems related to design which are briefly stated as follows:

(a) High cost of renovation, sometimes exceeding costs of equivalent new construction, resulting from inflexible design, over specific user requirements, and incomplete or faulty communication between user and designer;
(b) The lack in Canada of design information, such as provided by the King's Fund Hospital Centre in London, or the Scottish Hospital Centre, which are independently funded organizations in the United Kingdom, operated solely for the benefit of hospitals and providing information and advice, investigations and research, conferences and meetings, and exhibitions of equipment, etc.

SECTION 22

Construction

Definition

24. Construction is the process of producing the finished physical facility described by design.

Current Status

25. The construction industry in Canada, particularly in Ontario, is quick to accept new materials and new techniques which tend to improve speed of erection and to ensure quality performance for the expenditure made.

Comments

26. Notwithstanding a general rise in construction costs during the past 20 years, there have been improvements in building and schools. At the same time, the cost of creating and operating health service buildings such as hospitals, laboratories, and health service centres continues to rise disproportionately. This is due primarily to their increased complexity and size. Overall savings could well accrue if facilities were planned and constructed on a group or regional basis rather than almost invariably being planned from the point of view of a solitary institution.

27. In the construction of comparable projects, (e.g., the Study of Educational Facilities, Metro Toronto School Board), there is

useful research and experience available in new techniques of construction management and systems development. Except for isolated projects these techniques have not been applied to the construction of health facilities in Canada. There is a current attempt to develop large scale industrial co-ordination of hospital construction by the Minister of Health authorities in the U.K. Despite a growing annual expenditure in this field, no effort has yet been made to achieve group co-ordination of similar components, or the development and general use of mass-produced industrialized system components, such as exterior wall cladding, partitioning, and ceiling systems, factory assembled patient toilet rooms, and the like.

28. It is suggested that for health service facilities, economies could be gained by employing new forms of construction contract which have been profitably used in the construction of housing and schools. For example, the design consultants and the construction contractor may be selected on the basis of a joint project proposal, and then work together to achieve the project within agreed budget and time limits.

29. The guidelines for the pre-opening operating budgets for hospitals, particularly large or complex active treatment hospitals such as those used for teaching programmes, are totally inadequate to permit proper development of personnel, financial and technical systems. The involvement at an early date of hospital administrators, a director of nursing, systems and methods analysts, plant superintendent, and other specialized personnel in the planning of these health facilities appears justified. In the interests of smooth initiation of operation of major new health facilities and of ultimate economy of operation of these facilities, pre-opening budgets should become effective before initiation of construction and the categories of personnel supported broadened to include those who will have specialized responsibilities for operation of the facility.

Attachments

LEVELS OF HEALTH CARE AND SITES OF DELIVERY

LEVEL OF CARE	PATIENT'S REQUIREMENTS	SITE OF DELIVERY (EXAMPLES)		
		Institution (Patient not ambulatory)	Non-residential Facility (Patient ambulatory)	Home
Acute – Intensive	immediate access to diagnostic, treatment and supervisory services, to special facilities, and to personnel specially trained for emergency or life saving measures.	intensive care unit coronary care unit transplant unit	emergency department dialysis unit crisis intervention unit	resuscitation unit home dialysis
Acute – Intermediate	ready or continuous access to a broad scope of general and specialized diagnostic and treatment services, and skilled medical nursing and other health personnel.	active treatment hospital psychiatric unit psychiatric hospital	out-patient department practitioner's office	house call
Special – Rehabilitation	ready access to specialized rehabilitation facilities and skilled rehabilitation personnel; aimed at return towards normal life of patients severely disabled by physical, mental and social problems.	regional rehabilitation centre	out-patient rehabilitation department	physiotherapy home visit

LEVELS OF HEALTH CARE AND SITES OF DELIVERY

LEVEL OF CARE	PATIENT'S REQUIREMENTS	SITE OF DELIVERY (EXAMPLES)		
	Institution (Patient not ambulatory)	Non-residential Facility (Patient ambulatory)	Home	
Extended Care	skilled nursing care and special activation or recreation techniques; simple diagnostic and treatment services; intermittent medical attention.	convalescent hospital or unit chronic hospital or unit psychiatric hospitals	out-patient department mental health clinic	organized home care occasional home care
Sheltered Care	sheltered environment; assistance with the acts of daily living; basic nursing care; infrequent medical attention; limited diagnostic and treatment services.	homes for the aged – municipal – charitable rest home nursing home home for special care		home care (services and supervision)
Health Maintenance Care			physician's office public health clinics community clinic school health services industrial health services	

ATTACHMENT 2

BED RELATED HEALTH SERVICES FACILITIES

I PHYSICAL HEALTH FACILITIES

(a) Hospitals

1. **Active Treatment Hospitals** (229 – 38,989 beds)
   (Includes public general hospitals, Red Cross outpost hospitals, private contract and federal hospitals)

   – provide care to acutely ill in-patients who require the special facilities of a hospital providing comprehensive diagnostic and treatment services, daily medical attention and reassessment, and skilled nursing care and special techniques. Most active treatment hospitals also provide emergency and out-patient services.

2. **Special Hospitals**

   – provide diagnostic and therapeutic services for patients with specific conditions (e.g. Tuberculosis Sanatoria: 10 – 967 beds).

3. **Regional Rehabilitation Centres**

   – provide special facilities and staffing to give the necessary services to the severely disabled patient who has complicated physical, social and/or psychological problems, and who requires regular medical attention and reassessment. They are designed to serve the entire region in which they are situated.

4. **Convalescent Hospitals, and Units in Active Treatment Hospitals**
   (Includes public hospitals and units: 14–1,142 beds)

   – provide care to patients whose condition has passed the acute stage and whose condition can be improved by the special facilities of a hospital, regular medical attention and reassessment, skilled nursing care and special techniques.

5. **Chronic Care Hospitals, and Units in Active Treatment Hospitals**
   (Includes public hospitals and units, private contract hospitals and federal hospitals: 116 – 7,130 beds)

   – provide care to the unstable, incurable, or terminal long term patient requiring the special facilities of a hospital, periodic medical attention and reassessment, skilled nursing care, and special techniques.

6. **Nursing Homes Temporarily Approved for Chronic Care** (35 – 588 beds)

   – are given temporary approval in areas where a need exists, in the opinion of the Hospital Commission. They are expected to provide the same type of care as chronic care hospitals or units.

(b) **Related Facilities and Programme**

1. **Nursing Homes** (465 – 13,708 beds*)

   – provide care for those who do not need care in hospital but who cannot be cared for in their own homes; care ranges from minimal assistance in the acts of daily living to total bed care requiring intensive nursing.

2. **Rest Homes** (1 – 90 beds)

   – provide long term residential and highly concentrated nursing care to ailing and incapacitated persons who do not require care in hospital but who have some form of persistent ill health or handicap that cannot be looked after at home, and whose problems in maintenance and management are such that they cannot reasonably expect to be taken care of in a bed care section of a home for the aged.

3. **Homes for the Aged** (144 – 20,020 beds) (Include Municipal Homes for the Aged and Charitable Institutions)

* Including temporarily approved nursing homes and nursing homes licenced under *The Homes for Special Care Act.*

– provide care for those who do not need care in hospital, but who cannot be properly looked after in their own homes. The patient requires a sheltered environment, infrequent medical attention, basic nursing care and personal supervision for ambulatory, bed-to-chair or bed-ridden patients. Simple medications also may be required.

Three levels of care are provided:

(a) Normal care, for persons who are up and around, but who require some care and supervision.

(b) Bed care, for those who are confined to bed part--time or full-time, but who are not in need of hospital care.

(c) Special care, for mentally confused or senile who are not mentally ill, and who do not require care in a mental hospital.

4. **Comprehensive Home Care Programme** (13)

– provides for care of selected patients in their own homes through a programme which arranges for and co-ordinates the use of a wide variety of services procured from community resources.

II FACILITIES FOR THE MENTALLY ILL

(a) Psychiatric Hospitals

1. **Regional Hospitals for the Mentally Ill** (14 – 11,479 beds)

– provide a full range of diagnostic and therapeutic services; included are out-patient, day care, and in-patient services (short, intermediate and long term).

2. **Community Psychiatric Hospitals** (6 – 258 beds)

– provide a less broad range of service than the regional hospitals, but a more broad range than psychiatric

units of general hospitals; they provide little intermediate or long term care.

3. **Psychiatric Services in General Hospitals** (36 – 1,384 beds)
   (34) with in-patient services, and
   (11) with out-patient services only
   (2) Clarke Institute and Donwood Foundation
   – provide diagnostic and treatment services for the less disturbed cases of mental illness; length of stay averages 20-30 days. They provide little intermediate or long term care.

4. **Special Hospitals for the Mentally Ill** (2 – 1,631 beds)

   – provide care for the criminally insane, for the tuberculous mentally ill, for epileptics with a mental disorder, and for emotionally disturbed children.

5. **Private Hospitals for the Mentally Ill** (4 – 440 beds)

   – provide a variety of general and specialized (e.g. alcoholism) care for the mentally ill.

(b) **Facilities Related to Psychiatric Hospitals**

1. **Approved Homes: Halfway Houses** (78)

   – provide intermediary care for patients who are being rehabilitated back into the community but who have not yet been discharged from hospital; patients receive continuing therapy on a periodic or day care basis. These facilities are privately owned and operated, but they are psychiatric hospital approved, and care is subsidized at a daily rate.

2. **Residential Approved Homes** (39)

   – the Approved Homes not needed as Halfway Houses are being turned over to the Homes for Special Care Programme; they provide care for patients who are no longer in need of treatment in hospitals for the mentally ill.

3. **Residential Units**

   – these look after patients discharged from hospitals for the mentally ill who do not need psychiatric treatment. They provide a place to live, and general medical and nursing care. Some are on the hospital grounds.

4. **Homes for Special Care**

   – these are nursing homes or residential homes which provide care for patients who are no longer in need of treatment in hospitals for the mentally ill and who have been discharged from these facilities. They are privately owned and operated but are licensed by the Department of Health (Public Health Division) and care is subsidized at a daily rate.

III FACILITIES FOR THE MENTALLY RETARDED

(a) Hospitals and Training Facilities

1. **Regional Hospital Schools** (4 – 5,635 beds)

   – provide a variety of services required for the assessment, care, treatment, training, and rehabilitation of the mentally retarded.

2. **Specialized Training Facilities** (5 – 904 beds)

   – provide care and training for those who are able to work, or are trainable in an occupation.

3. **Facilities for the Profoundly Handicapped Child (operated by private boards)** (10 – 1,193 beds)

   – provide medical and nursing care for those who cannot benefit from training; almost all patients suffer from multiple handicaps, and require total care.

(b) **Related to Facilities for the Retarded**

1. **Approved Nursing Homes** (10)

   – provide care for children who are severely handicapped but who require a less intensive level of nursing care than is provided in Facilities for the Profoundly Handicapped. These are going to be turned over to the Homes for Special Care Programme.

2. **Approved Homes** (50)

   – provide a home-like setting for a number of mentally retarded who are no longer in need of the more specialized care provided in the Hospital School, and for a group of young people who are attending a community programme and who would benefit from a small home-like setting; no nursing care is required. These are going to be turned over to the Homes for Special Care Programme.

3. **Homes for Special Care**

   these are nursing homes or residential homes which provide care for patients no longer in need of treatment in hospitals for the retarded. They are privately owned and operated, but are licensed by the Department (Public Health Division) and care is subsidized at a daily rate.

IV **REGIONAL CENTRES FOR CHILDREN WITH MENTAL AND EMOTIONAL DISORDERS** (8 – 420 beds)

– provide for diagnosis, assessment and treatment; provide out-patient, day care, and in-patient services for the mentally ill and retarded child and for those suffering from perceptual defect and other neurological disorders.

DEFINITIONS

Planning — The recognition of a need and the preparation of plans to meet the need
Approval — Acceptance in principle of a programme the detailed review of plans and actions for their implementation.
Finance — The provision of funds to execute an approved programme

CODE:

I — Individual
P — Private
C — Local groups or boards
ADARF — Alcoholism and Drug Addiction Research Foundation
OHSC — Ontario Hospital Services Commission

D of H — Department of Health
D of PW — Department of Public Works
D of Ed — Department of Education
D of UA — Department of University Affairs
D of SFS — Department of Social and Family Services
Fed — Federal Government

Item No.	FACILITY OF PROGRAMME	CAPITAL CONSTRUCTION			OPERATING			COMMENTS
		Planning	Approval	Finance	Planning	Approval	Finance	
1	**PHYSICAL HEALTH FACILITIES** General hospitals (including active and/or convalescent and/or chronic, and out-patient – 215 hospitals).	C	OHSC	OHSC 2/3 C 1/3	C	OHSC	OHSC C	**Capital:** The O H S C 2/3 consists primarily of Provincial monies (grant plus loan) but also includes a small and variable amount of Federal money **Operating** O H S C involvement is through cost review of operating budgets and of actual expenditures, community involvement includes costs not met through O.H.S.C e.g. non-allowable costs, non-approved costs, self pay, Workmen's Compensation Board, etc. Salaries for radiologists and pathologists are allowable costs and are included in the hospital budget.
2	General hospitals as above, but including in addition psychiatric in- and out-patient facilities (34 with in-patient, 11 with out-patient only).	C	D of H OHSC	OHSC 2/3 C 1/3	C	OHSC D of H	OHSC C D of H	**Capital** Same as Item 1 except for Department of Health involvement. **Operating.** Same as Item 1, but in addition, the monies required to reimburse the hospital for medical salaries relating to psychiatric out-patient services are provided by the Department of Health through the O H S.C and are incorporated into the hospital budget.
3	Red Cross out-post hospitals (13).	BASICALLY THE SAME AS ITEM 1						**Capital** The Canadian Red Cross Society assumes responsibility for a portion of the Community's share. **Operating:** Same as Item 1.
4	General hospitals-teaching, (including research facilities, and regional rehabilitation centres)	University C	Senior Co-ordinating Committee OHSC	OHSC FED	University C	OHSC	OHSC University C	The Senior Co-ordinating Committee consists of representatives of the Depts of Health and University Affairs and of O H S C This Committee is responsible for the educational and research aspects. **Capital:** The facilities for teaching are financed 100% through the O H S C and the Federal Government. Financing of other construction and renovations is O.H.S.C. 2/3 Community 1/3, except for University (on campus) hospitals where it is 100 O.H.S.C. and the Federal Government. **Operating:** Same as Item 1.
5	Rehabilitation Facilities (non-public hospital 20) (Facilities for ambulatory patients).	C	D of H	D of H 2/3 C 1/3	C	OHSC	OHSC D of H P	**Operating.** Budgets are reviewed with the assistance of the Department of Health and payments are made by O.H.S.C. for the insured services The Department of Health is responsible for programme approval.
6	Private Physiotherapy Plan Approved physiotherapy facilities for office and home treatment. (212)	P	OHSC	P	P	OHSC	OHSC	**Operating.** Payment is made on the basis of $3 50 per visit to an office for treatment and $4 50 per home visit O.H.S.C approvals of capital construction and operating activities have been delegated to a working committee of the Department of Health and O.H.S.C. staff.

TABLE 1 continued

Item No.	FACILITY OF PROGRAMME	CAPITAL CONSTRUCTION			OPERATING			COMMENTS	
		Planning	Approval	Finance	Planning	Approval	Finance		
7	Active and chronic private contract hospitals (e g Toronto Doctor's Hospital, Thorold-Maplehurst – 39 hospitals).	P	OHSC	P	P	OHSC	OHSC P	**Operating:**	From a cost review of operating budgets, a per diem rate is established which may be adjusted after a year end audit This rate includes (a) depreciation on the physical plant based on the Canadian Hospital Accounting Manual or Income Tax Schedules; (b) return on investment at 6½%; (c) interest on debt.
8	Active, convalescent and chronic Federal hospitals (e.g. London, Westminster, Sandy Lake Nursing Station – 10 facilities).	FED	FED	FED	FED	FED OHSC	FED OHSC	**Operating**	O H S C payment is made on the basis of a mutually agreed upon per diem rate
9	Temporarily approved nursing homes (35 homes)	P	OHSC	P	P	OHSC	OHSC	**Operating.**	Approved temporarily by O H S C for the provision of chronic care Payment for the provision of care to chronically ill patients is made on the basis of $9.50 per patient day.
10	Tuberculosis sanatoria (10 Sanatoria)	C	D of H	D of H 1/3 FED 1/3 C 1/3	C	D of H	D of H C	**Operating**	The Department of Health is responsible for net allowable operating costs Payment is made on the basis of an annual budget, subject to prior approval by the Department of Health and year end audit and adjustment.
11	Nursing Homes (465 including 35 homes temporarily approved by O H S.C and the 255 nursing homes in the Homes for Special Care Programme).	P	D of H	P	P	D of H	I D of SFS P FED	**Operating:**	Residents who are not in O H.S.C approved facilities for chronic care and who are not in the Homes for Special Care Programme are financially responsible for their own care Care for the recipients of public assistance is subsidized at the rate of $9 50 per day of care by the Department of Social and Family Services.
12	Rest Homes (1)	C	D of SFS	C 1/2 D of SFS 1/2	C	D of SFS	I C D of SFS	**Capital** **Operating:**	Costs of construction are shared on a 50-50 basis between the Province and one or more participating municipalities. Individuals pay for care insofar as their means permit Balance of operating cost is shared by Province – 70%, and participating municipalities – 30%.
13	Homes for the aged (municipal – 73).	C	D of SFS	C 1/2 D of SFS 1/2	C	D of SFS	I C D of SFS	**Capital:** **Operating:**	Same as Item 12. Same as Item 12.
14	Homes for the Aged (non-profit Charitable Institutions 71)	P	D of SFS	P D of SFS	P	D of SFS	I P D of SFS	**Capital.** **Operating:**	Construction costs are in part met by grants from the Province of $5,000 per bed up to 1/2 the cost, whichever is lesser Individuals are charged in accordance with a scale established by the institution For indigent persons, the Province makes a contribution up to 80% of net costs, not exceeding $8.00 per day.

TABLE 1 continued

Item No.	FACILITY OF PROGRAMME	CAPITAL CONSTRUCTION			OPERATING			COMMENTS
		Planning	Approval	Finance	Planning	Approval	Finance	
15	Home Care Programme (13)	N/A	N/A	N/A	C	Inter-departmental Committee	D of H OHSC	**Operating** An interdepartmental Committee on Home Care, comprised of representatives of O.H.S.C. and Department of Health reviews and approves local programme and budgets. Half of the cost is borne by the Department of Health, and half is met by O.H.S.C.; payment is made through O.H.S.C. Auditing is the responsibility of the Department of Health.
16	**MENTAL HEALTH FACILITIES** Psychiatric hospitals (including regional and special hospitals and residential units). (16 hospitals – formerly called Ontario Hospitals).	D of H	D of H	D of PW	D of H	D of H	D of H	**Capital:** Subject to overall provincial government priorities.
17	Community psychiatric hospitals (6 hospitals, e.g Royal Ottawa Sanatorium psychiatric hospital)	C	D of H	D of H FED	C	D of H	D of H through OHSC C	**Capital** New construction in a Community Psychiatric Hospital is supported by a grant of a fixed amount per bed and per unit of floor space. The Regulations in force provide Provincial Grants of $8,500 per bed, and $3,200 per 300 square feet of floor space or the actual cost whichever is lesser. The Federal Grant of $2,000 per bed and $2,000 per 300 square feet of floor space are additional to the Provincial Grants. The Grants provided for renovation projects, are on the same basis, but at a lower level, viz., $3,000 per bed and per 300 square feet of floor space. Here again, Federal Grants provide an additional $2,000 per bed, and $2,000 per 300 square feet of floor space, providing the total Federal and Provincial Grant does not exceed the actual cost. It is understood that this will be changed so that the Province will pay 2/3 of construction costs, and the community 1/3. **Operating:** The Department of Health is responsible for the net allowable operating costs of both in-patient and out-patient services provided by Community Psychiatric Hospitals. This assistance is paid through the Ontario Hospital Services Commission on the basis of an annual budget, subject to prior approval by the Department of Health and year end audit and adjustment.
18	General hospitals with psychiatric in-patient and facilities (repeat of Item 2.)	C	D of H OHSC	OHSC 2/3 C 1/3	C	OHSC D of H	OHSC C D of H	**Capital** Same as Item 1 except for Department of Health involvement **Operating** Same as Item 1 but in addition the monies required to reimburse the hospital for medical salaries relating to psychiatric out-patient services are provided by the Department of Health through the O.H.S.C. and are incorporated into the hospital budget
19	Public hospitals for psychiatric illness (only Clarke Institute).	D of H	D of H	D of H		D of H	D of H through OHSC	**Operating** The Clarke Institute is a teaching hospital with the same involvements as item 4. Payment is made through the O.H.S.C. and charged to the Department of Health
20	Public hospitals for alcoholism and drug addiction (only Donwood Foundation).	C	OHSC	OHSC 2/3 C 1/3	C	OHSC	OHSC	

TABLE 1 continued

Item No.	FACILITY OF PROGRAMME	CAPITAL CONSTRUCTION			OPERATING			COMMENTS	
		Planning	Approval	Finance	Planning	Approval	Finance		
21	Alcoholism and Drug Addiction Research Foundation facilities.	ADARF	ADARF	D of PW	ADARF C	ADARF	D of H	**Operating:**	Attempts are made to tie operations at the local level to an existing health facility
22	Regional hospital schools and specialized training facilities (9 facilities – e.g. Smiths Falls Hospital School, and Edgar Adult Occupational Centre).	D of H D of Ed	D of H	D of PW	D of H D of Ed	D of H D of Ed	D of H D of Ed	**Capital:** **Operating**	Same as Item 16 Educational programmes are staffed and operated by the Department of Education
23	Institutions for Nervous Ailments (e.g. Waterloo-Sunbeam Home; Brantford Sanatorium-Annex; Kingston-Institute of Psychotherapy; 4 facilities for the mentally ill, and 10 for the profoundly handicapped child).	P	D of H	P	P	D of H OHSC	D of H through OHSC	**Capital:** **Operating**	Special grants may be provided through an accountable warrant Two methods of financing are used – (a) Same as Item 7 (b) For some facilities, financial assistance is provided on the basis of an annual budget, subject to prior approval, year end audit and adjustment In both instances, payment is made through the O.H.S.C. and charged to the Department of Health.
24	Regional Centres for children (8 centres).	D of H		D of H	D of H	D of H	D of H	**Capital:**	Same as Item 16.
25	Approved nursing homes and residential homes (177 facilities).	P	D of H	P	P	D of H	D of H P	**Operating**	Payment for the provision of care is made on the basis of $9.50 per day in nursing homes, and $4.00 per patient day in residential homes.
26	Homes for Special Care (255 nursing homes, 195 residential homes).	P	D of H	P	P	D of H	D of H P	**Operating**	Both nursing homes and residential homes are included in this programme. Payment for operations is the same as under Item 25.

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